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*Medical and Chirurgical Faculty of the State of Maryland*

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# *Maryland* STATE MEDICAL JOURNAL

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## EDITORIAL

WHITMER B. FIROR, M.D.\*

This JOURNAL, now in its third year of publication, is potentially the greatest single unifying factor in the history of our Society, a Society born only a few years after the birth



WHITMER B. FIROR

of these United States. Its ultimate effectiveness will depend largely upon you, the reader, because the comprehensive knowledge which you can gain as to the activities of your most

\* Vice-Chairman, The Council of the Medical and Chirurgical Faculty.

important organization in the State of Maryland will enable you to play a more productive role in the ever-expanding responsibilities of the Faculty.

It is unfortunately true that only a small minority of the practitioners of medicine in Maryland have ever been actively engaged in the affairs of our Society. This deplorable situation can be explained only by a lack of understanding or a lack of conscience on the part of many members of the profession.

Have you ever given even ten minutes of serious thought to your Society other than when you grudgingly paid your annual dues? It may not have occurred to you that the majority of the state societies throughout the land require somewhat more financial support than is requested by the Medical and Chirurgical Faculty. It may not have occurred to you that the maintenance of high standards of medical care, of proper doctor-patient relationships, and of good public relations in general depend upon the existence and action of your professional organization. In other words, it may not have occurred to you that your State Society is the most important body in your professional life.

It is not an overstatement, therefore, to indicate that it is both a duty and a privilege of every practicing member of the profession to participate at some time in the affairs of his local and state organizations. Dues should be paid with gratitude; they should also be paid promptly, especially in consideration of the fact that physicians' defense is becoming such an important factor in this trying age when some patients are concerned with money easily gained rather than the concept of human fallibility. Meetings should be attended as regularly as possible with the conviction that these meetings should take precedence over all other professional gatherings. Your wives can do nothing more fruitful in their spare time than to become active in the Woman's Auxiliary. Finally, go to 1211 Cathedral Street to browse in the fine library, look in upon the director, and gain some knowledge of the magnitude of work being done in cramped quarters by self-sacrificing employees who have often almost broken their hearts for you and for me. The least one can do is to give them a word of appreciation of their splendid efforts.

#### VA PLANNING ON 110,000 DAILY PATIENT LOAD FOR FISCAL 1956

A. M. A. Washington Letter, No. 76

Veterans Administrator Harvey Higley says the agency is planning on a 110,000 daily patient load for its hospitals in fiscal 1956 (starting July 1, 1955). On the basis of a current staffing of 114,000 beds and a 90% occupancy, the new figure would mean approximately 8,000 more beds would have to be added. One estimate of hospital experts is that the cost of the 8,000 additional beds would be well in excess of \$120 million. Commented Mr. Higley in testimony before House Veterans Affairs Committee on the 110,000 figure: "We believe that isn't far off from the Bureau of the Budget's thinking, too." For the current fiscal year, the daily average patient load has been 103,000. The fiscal 1955 budget for VA providing for a daily load of 105,000 patients went to the White House this week. Under questioning on the 1955 budget, Mr. Higley said VA would be able to do a better job during the next year if it had another \$6 million. However, Reps. Pat Kearney and William Ayres raised the point that this extra money would be for non-service-connected cases and that it would, on that basis, be difficult getting Congress to go along.

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# COMPLETION OF 1954 TRANSACTIONS

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## Scientific Papers

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### CLUES IN CARDIOVASCULAR DIAGNOSIS AND TREATMENT<sup>1</sup>

PAUL DUDLEY WHITE, M.D.<sup>2</sup>

DR. BENDER B. KNEISLEY, PRESIDENT: Ladies and Gentlemen, I should like to present the Chairman of our Council, and the now President of the American Heart Association, Dr. E. Cowles Andrus, who will introduce our speaker.

DR. E. COWLES ANDRUS: Dr. Kneisley, Members of the Faculty and Guests, I am very grateful for the privilege which Dr. Kneisley has conferred on me of introducing the Finney Fund lecturer who will speak on "Clues in Cardiovascular Diagnosis and Treatment." I am grateful because it gives me some opportunity to pay honor to an old friend. He has been a student all his life, student of Cardiovascular disease and physiology in man. He has become a scholar, he has moreover imparted his scholarship and his wisdom and experience to a large group which includes eminent cardiologists all over the country and in other countries.

In the practice of his profession, he has traveled from Alaska in the North, to Argentina in the South, and literally around the world, and he has followed the biblical adage of interest in all things both great and small. He told me at dinner that the statement made about him, that he has taken electrocardiograms on humming birds is an exaggeration. He has only listened to their hearts. He has, however, studied in detail the heart of the elephant and in late years has turned his interest to aquatic animals.

He has recorded the electrocardiogram of the beluga whale, and it is not because of his own shortcomings that he failed to record it on larger whales; the apparatus didn't work. But he tells me that he has plans for next summer or the year after in the Bay of Whales, and he has just returned from a trip to Mexico where he went to represent the Cardiologists of this country, and incidentally to pull a few diplomatic strings for

access to whale fishing and studying territories in the Gulf of Southern California.

Our speaker is certainly known to you all. He is the author of the Standard Text book on Heart Disease. He is the Dean of American Cardiologists, Dr. Paul Dudley White.

Dr. Andrus, Dr. Kneisley, Dr. Compton, Ladies and Gentlemen, I appreciate very much the honor of being asked to speak this evening in honor and memory of Dr. Finney. I met Dr. Finney in Paris I think for the first time when he was in the uniform in which you see him in the portrait on the wall. I was a 1st Lieutenant at the time in the Massachusetts General Base Hospital Unit near Bordeaux, and occasionally we traveled to Paris to attend meetings and conferences; the Big Bertha was shelling Paris, I remember, on one occasion, and I then met Dr. Finney who spoke at some of the meetings and who was very kind to us. In that way I got to know him first. I saw him a few times afterwards, and it is a great privilege to be here in his honor tonight.

I think that I may be bringing, "Coals to Newcastle," talking on this subject here, but when I suggested this subject of *Clues in Cardiovascular Diagnosis and Treatment*, I was buried in Preparation of a little book on the subject, and so it was of prime interest at that moment.

Obviously, everyone has his own pet clues and in fact I have searched for some from various

<sup>1</sup> John M. T. Finney Fund Lecture, Annual Meeting, Medical and Chirurgical Faculty of Maryland, Baltimore, Maryland, Tuesday evening, April 27, 1954.

<sup>2</sup> Formerly Clinical Professor of Medicine, Harvard Medical School; Executive Director, National Advisory Heart Council and Consultant, Massachusetts General Hospital, Boston, Massachusetts.

friends of mine around the world, and I have added their pet clues to my own in the process of assembling this little book. Since then other things have happened and I am full of another story that I would like to tack on to this subject tonight. I shall therefore give you fewer clues (but some of the more important ones) and a bit of my latest adventures not with reference to whales, but on another much more important subject.

#### CLUES IN THE FAMILY HISTORY

Clues can be found, of course, in many ways; for cardiac diagnosis or for any diagnosis they come in large part through the history, the simple questioning of the patient, and observation of the patient. I believe that that is the most important way in which we can gather clues. One of the major clues is that of heredity. To gather that means obtaining a careful family history which is often neglected these days. Moreover one should go back to the grandparents and not just to the parents and brothers and sisters. I think it is most important, so far as cardiac disease of any sort is concerned, to know what the family history has been.

To illustrate the fact that one should go back of the immediate parents to the grandparents at least, is borne out by my own experience. My father's mother died of cholera in the last epidemic that came to New England, I expect from the East, in about 1860, when she was only 24 years old. My father was less than a year old then and his mother died on Bunker Hill of a disease which we never see now.

In fact I never saw a case of cholera until two years ago when I went out to Pakistan in East Bengal, and yet my own grandmother died of it. My father's father died of tuberculosis at the age of thirty odd. And so my father was brought up by his mother's parents on their farm in Randolph, Massachusetts. Meanwhile, however, his grandmother, my great grandmother, his father's mother, born in 1800, died in 1900; that is much more important I am sure so far

as I am concerned than the deaths of my grandmother from cholera and of my grandfather from tuberculosis.

Therefore one should get a fairly full history of the family. This is very important, and as I say, is often neglected. I find that most doctors with whom I speak, whose cases I am seeing, have little knowledge of the family history unless they are family doctors. Of course the family doctor has a great advantage there. He has followed his patients for years and often was the doctor of the patient's father and now may be the doctor of the patient's child as well.

#### CLUES IN CORONARY HEART DISEASE

Let me now take up some of the specific cardiovascular diseases and conditions more or less in the order of their importance. We come first to Coronary Heart Disease. I spoke on that subject in Baltimore a few months ago, but it is so important that I'd like to reemphasize some of the things I may have said then, and add one or two others. I shall confirm the assertion that this is the most important health problem which concerns those of us who are working in cardiovascular disease. It will also be the end of my story this evening, in the form of one of my latest adventures. The three common forms clinically of Coronary Heart Disease are 1) coronary insufficiency, shown by the symptom of Angina Pectoris, 2) the clinical condition of myocardial infarction or of coronary thrombosis with or without myocardial infarction, and 3) the various kinds of heart blocks, in particular a-v block and bundle-branch block which appear in middle or older aged people and which are certainly indicative of coronary heart disease in the majority of cases. These constitute the only conditions which should be called coronary heart disease, but I find a very loose terminology, everywhere in the world. Arteriosclerotic heart disease is a common but misleading diagnosis. If you really mean arteriosclerotic heart disease you mean coronary atherosclerotic heart disease; abbreviated, it may be called coronary heart dis-

ease. It is not aortic sclerosis or generalized arteriosclerosis which need not affect the heart at all.

Recently in the study in Naples that I will speak of later, we found great confusion in diagnosis. Some were still diagnosing myocardial sclerosis and arteriosclerotic heart disease for a wide variety of conditions, for example, for atrial fibrillation in a middle aged or older person who gave no evidence of more than an irritability of the heart.

The first clue to the diagnosis of coronary heart disease is the symptom of coronary insufficiency itself which has to be obtained usually by history. Occasionally one can observe it but I do not like to have to test my patients. You can get an adequate story by careful questioning in nearly every case. You may need ten or fifteen minutes to work the story out properly but let the patient tell his own story; then have him amplify it by asking just where the discomfort is felt, what kind of discomfort it is, and whether it is related to breathing. Often times it is not called a pain. It may be a feeling of tightness or pressure or a "difficulty in breathing," but it isn't dyspnea. That is quite clear. Can a person point to the location with one finger? No, the person can't point to the site of the pain with one finger; the whole hand has to be used. That is very important. The palm of the hand, sometimes both hands are put across the front of the chest. Generally, of course, the symptom is central or substernal in location but it can be on either side. It is unusual for it to be only precordial instead of substernal, but the use of the palm, in the gesture of the patient, covers a wider area than that at the tip of a single finger.

This symptom was first fully described and given its name by Heberden in 1768, but I learned in Bologna a few weeks ago that it was mentioned before Heberden, without being given the name of angina pectoris. I was shown the book in which the description of angina pectoris appeared in 1747; taking great interest in this

reference I was presented with the book itself and I have brought it here. I never heard of this book before, even though I am very much interested in old medical books. Thus this book is quite new to me and this reference to angina pectoris also, and I am sure that it is new to almost everybody else. The book is printed in both Latin and Italian, it was published in 1747 in Venice, and it is entitled "The Medical Consultations of Marcello Malpighi and Giovanni Maria Lancisi." Thus these were some of the medical consultations of these two men, great leaders in Medicine in Italy in the Seventeenth and Eighteenth Centuries. Malpighi dying in 1690 and Lancisi in 1720.

The first consultations, about sixty in number are those of Malpighi, and most of them are in Latin. There began to be more Italian printed when Lancisi came along.

Before I forget it, I would add that while I was walking along the streets of Bologna a few weeks ago to see some of the sick poor at home, to make sure that we weren't missing cases who didn't enter the hospital but who were sick at home of heart disease, I passed along a street in a rather poor district of the city where there had been bombing during the war and where there was still evident a good deal of destruction, some of it repaired. As I walked along, the city doctor, the Health Department Physician who accompanied me, pointed to a doorway of a brick house we were passing. There over the door on a little marble slab was the statement that here in the seventeenth century lived Marcello Malpighi. About ten doors further down the same street on the same side was another marble slab over a doorway which said that Morgagni lived there in the eighteenth century. Thus within ten doors of each other in Bologna were the homes of those very noted Italian physicians. As you know, the statue of Galvani and his frog is also in Bologna, and Marconi lived in Bologna. It's a very historic scientific city and contains the oldest medical school still in existence. Moreover, the University of Bologna is still

going strong. Bologna followed Salerno which was the site of the first Medical School, as we define such today, established in about the year 1000; less than a couple of hundred years later came Bologna and after that Padua. It was quite thrilling to be in Bologna a month ago.

Of the first three consultations of Malpighi, the very first concerned Pope Innocent XII. The second was on the King of Poland who had some palpitation. The third was on the Queen of Poland who also had palpitation. Consultation No. 30 concerned a man who had characteristic periodic substernal pain radiating to the jaws and to the teeth. Another case suffered from periodic sternal pain radiating down the left arm, excited by stimuli of one kind and another. At autopsy his coronary arteries were unfortunately not examined. A so-called polyp was found, undoubtedly a post-mortem clot which was misconstrued for many centuries, as a type of heart disease, post-mortem clots found in the heart distracting the attention of pathologists until Kerckring set them straight. But I would like to say that at the present time some of the best study in pathology which I have seen, especially in the cardiovascular field, is being carried on in Bologna under Professor Businco who is the director of the Pathological Institute. If any of you would like a good review of cardiovascular findings, especially of aortic sclerosis during the past fifteen or twenty years, you should write to Professor Businco because he has aortograms of every case autopsied. In every case there has been prepared a diagram of the aorta, with the exact spots shown where there was atheroma or calcification or other abnormality. I don't know of any other place where such details have been collected.

I suppose that if one should go back still further to earlier works unknown to us, one might find still earlier descriptions of angina pectoris. This case report antedates Heberden by twenty-one years. Keefer and Resnick in 1928 explained the mechanism of angina pectoris very well. Prior to that important paper of

Keefer and Resnick in 1928, there was a good deal of confusion about it, but there isn't so much now. Some had thought that the pain of angina pectoris was located in the aorta, others in the heart muscle or in the nerves, or in the coronary arteries themselves. The other day, however, I acquired another old book, one by Allan Burns on the heart, published in 1809. This is ten years after the book *Syncope Anginosa* was published by Parry in 1799, in which Jenner's famous letter is recorded, first calling clear attention to the association of coronary atherosclerosis and calcification to angina pectoris and sudden death. Ten years later Allan Burns wrote this book which was published in Edinburgh in 1809. In the chapter entitled "On Disease of the Coronary Arteries and on Syncope Anginosa," he wrote "It has been long known that although the heart is always full of blood, yet it cannot appropriate to its own wants a single particle of fluid contained in its cavities. On the contrary, like every other part, it has peculiar vessels set apart for its nourishment. In health, when we excite the muscular system to more energetic action than usual, we increase the circulation in every part, so that to support this increased action, the heart and every other part has its power augmented. If, however, we call into vigorous action a limb round which we have with a moderate degree of tightness applied a ligature, we find that then the member can only support its action for a very short time, for now its supply of energy and its expenditure do not balance each other; consequently it soon, from a deficiency of nervous influence and arterial blood, fails and sinks into a state of quiescence." I have often talked to patients about this without realizing that this had already been written 150 years ago; when a tourniquet is put around the arm and there is repeated contraction of the hand, after a while the muscles of the forearm will ache. Release the tourniquet and the ache will go away. Well, this was, as quoted, clearly described by Allan Burns in 1809.

"A heart, the coronary vessels of which are

cartilaginous or ossified is in nearly a similar condition; it can, like the limb, be girthed with a moderately tight ligature, discharge its function so long as its action is moderate and equal. Increase, however, the action of the whole body, and along with the rest, that of the heart, and you will soon see exemplified the truth of what has been said, with this difference, that as there is no interruption to the action of the cardiac nerves, the heart will be able to hold out a little longer than the limb." Sometimes it doesn't however.

"If a person walks fast, ascends a steep, or mounts a pair of stairs, the circulation in the state of health is hurried, and the heart is felt beating more frequently against the ribs than usual." This applies to a healthy person. "If, however, a person with the nutrient arteries of the heart diseased in such a way as to impede the progress of the blood along them, attempt to do the same, he finds that the heart is sooner fatigued than the other parts which remain healthy." That is so characteristic. The only thing wrong with most of my patients with coronary heart disease is the state of the coronary arteries. They are perfectly healthy in every other way, with no peripheral sclerosis; often they are young and seemingly healthy, perhaps forty or forty-five years old. "When, therefore, the coronary arteries are ossified, every agent capable of increasing the action of the heart such as exercise, passion, and ardent spirits" [which have been sometimes recommended to prevent this] "must be a source of danger."

There are many cases that are said to have pseudo-angina pectoris, but there is either angina pectoris or there isn't. I think that such a term shouldn't be used. We should describe the pain and try to ascertain its cause but not label it as pseudo-angina.

The heartache of neurocirculatory asthenia is quite different. Such discomfort is an ache, not an oppression. It often lasts for hours and is associated with other symptoms. So often the symptom of angina pectoris in the average pa-

tient of mine who is forty-five or fifty years of age, is the only complaint. It usually comes on effort; it doesn't need to be very strong pain or discomfort; and there doesn't need to be very much effort to cause it. There is rarely any sense of impending death. In fact when there is a sense of impending death, usually there is predominately a nervous state whether heart disease is present or not. Many of the patients with neurocirculatory asthenia whom I see with no coronary heart disease at all, are much more afraid of imminent death than are the patients with angina pectoris, who often are not greatly worried. I would repeat that angina pectoris is likely to be the only symptom; the patients feel perfectly well between attacks and if they don't exert themselves too much they can go for months without an attack.

Another very important clue is this. Coronary insufficiency, is often very variable. It isn't in most persons an unchanging symptom over the years. A few have severe angina pectoris on effort for years, and those cases need more radical treatment if they are very much limited, but the average person that I see with angina pectoris on effort or angina pectoris decubitus, has it in the same degree only for a relatively short time, a matter of months at the most. I have never seen a patient with angina decubitus, that is angina pectoris at rest, lasting for more than a few months. That patient either dies or develops coronary thrombosis as an acute heart attack, with or without myocardial infarction, or gets better, sometimes perfectly well.

And I have a good many patients who are perfectly well ten or twenty years after having been seriously ill pro tem with angina decubitus. There is no doubt in the world about that. In the old days if a person with angina pectoris got better, the general conclusion was that the diagnosis must have been wrong; therefore the doctors ruled out all the recovered cases. That is one of the chief reasons why the prognosis has been improving in the last twenty years. We now recognize the mild cases of coronary heart dis-

ease that get well, and don't fool ourselves into thinking that they are just "indigestion." Some long survivors have scars and some do not.

There may be radiation of pain, or the pain may start in an unusual place, as in the back or the wrist, or some other such unusual place. Rarely does the pain radiate lower than the midline, that is lower than the waist. I can't recall any patient who has had angina pectoris—that is coronary insufficiency pain—start below the belt. Many cases have had pain start in the shoulder or upper back, usually as a result of something abnormal in that part of the body, to which this pain is sympathetically referred. If such a person has pain start in the back or the right wrist and continues to exert himself by walking fast or uphill, the pain will gradually spread from the back or the right wrist to the substernal region. Sometimes the patient stops before that happens. Effort, then, is the key to such a symptom, sometimes with electrocardiographic corroboration.

Adam-Stokes attacks, fortunately rare, are commonly the result of coronary heart disease. Very infrequently they may result from other conditions, particularly severe rheumatic myocarditis.

Electrocardiographic evidence has, of course, great corroborative value in the diagnosis of coronary heart disease, but I think I spend more time nowadays in "undiagnosing" patients who have been "overdiagnosed" than in the reverse. I do that at least once a week in the case of electrocardiograms sent to me from a distance. Sometimes a so-called coronary patient comes in and I find merely some variation of the normal electrocardiogram. Actually we don't know the range of the normal yet. Normal variations are much too often misinterpreted as evidence of coronary heart disease.

It is always important to send for previous electrocardiograms if there is the least doubt. Once in a while I have been fooled by not doing that and so I always make a point of getting the old records because serial tracings are often

absolutely essential. Just because an electrocardiogram is normal now doesn't mean that it was normal two years ago. One can observe a complete recovery of an abnormal electrocardiogram as a physical finding in the course of years, and so one must get all the evidence there is in the past. This is essential both as regards X-ray films and as regards electrocardiograms. Don't fail to do that; now and then you will be surprised at what you see.

Sometimes there has been acute pericarditis in the past as shown by clinical evidence and by electrocardiograms that were abnormal then, but which have now become normal.

Moreover, there is normally not infrequently a slight elevation of the ST segments in the limb leads, and particularly in the V3 or V4 chest lead that is wrongly said to indicate heart disease. Also even the exercise test may be misread by the tester. One can find physiological reactions which will sometimes simulate coronary insufficiency, such as slight depression of the ST segments after exercise when there is quickening of the heart rate. The borderline of normal varies very much according to the individual who is making the interpretation. I have myself encountered several severe cardiac neurotics, aged 40 to 50 years, who have had perfectly normal hearts, but who, after an exercise test were said to have serious coronary heart disease. As in the law courts, we shouldn't condemn a person unless we are pretty sure of our evidence. At the same time even if we do have to "condemn" a patient, it is very important to emphasize the fact that our viewpoint of coronary heart disease has changed very much. We mustn't be Pollyannaish about it, but nevertheless, it is perfectly true that there are some people who have temporary changes in the coronary circulation, a touch of coronary heart disease, who are quite well later on. We can justifiably emphasize that fact to any patient we see with early coronary heart disease, even though severe, because we encounter some very severe cases who are quite well years afterward.

One of my patients to whom I occasionally refer is now 78. I saw him first 27 years ago when we were just beginning to diagnose coronary heart disease and myocardial infarction. He was a fairly average severe case, and he still shows a scar both by fluoroscope (which reveals a little cardiac aneurysm) and by electrocardiogram. He has never had any more trouble in the last 27 years. Now at 78, he plays golf with no difficulty whatsoever. Of course one can overdo exercise, but nevertheless it is very important not only not to make errors by overdiagnosing, but also to encourage those who have the disease and to get their cooperation in sensible living.

One of the clues to proper treatment of coronary heart disease is this very knowledge that a patient may spontaneously, merely with the application of common sense, get over his angina pectoris or recover well from myocardial infarction, with no special treatment at all. I saw a patient in Rome a few weeks ago who was convalescent from coronary thrombosis, an American tourist who happened to be over there, doing very well, requiring no treatment. But a very good Italian doctor with whom I saw the patient, wanted to know what drugs we would advise, and I said that I didn't think that any medicine was needed; but just a little further rest. She had had a good recovery. And he said, "don't you think a little aminophylline would be good?" I answered that I saw no harm in aminophylline and so we prescribed a little aminophylline. When we came out and walked down the street, he said "you don't use many drugs, do you?" I said "no, we don't use very many drugs in the U. S. A." He said that his conscience would hurt him unless he gave at least one medicine, because of the traditional custom of therapy in Italy.

A good deal of the credit that many medicines have wrongfully received, including even aminophylline which can be helpful, should be accorded to the natural recovery that is common in coronary heart disease, recovery that would have occurred anyway. I am absolutely sure of

that. The same is true of some of the radical surgical operations and other procedures. Hence one ought to prescribe as a rule at least six months probation before one undertakes any radical treatment. Incidentally, that is true of many conditions beside heart disease. Don't do a surgical operation for coronary heart disease or give irradiated iodine until you are quite sure that there is no change going on for a certain number of months. See what nature can do first, meanwhile using common sense measures.

Now, as to other corroborative evidence, clues, some of which are important. Sex is very important, of course. We know that the male up to the age of fifty is preponderantly the victim of coronary heart disease in contrast to the female. Therefore, if you have a patient who is a woman 35 years old, complaining of chest pain, the chances are about a hundred to one that the pain isn't angina pectoris. There is almost always some other cause for the pain. You may remember our series of two hundred cases of coronary heart disease under the age of forty. There were only seven women among the two hundred. At least two of those women were mesomorphs, which I will discuss further in a moment. Two others had hypertension. In other words there was generally a particular reason for coronary heart disease even in those women. The diagnosis of coronary heart disease in a young woman in the twenties should be viewed with considerable skepticism. One young woman aged 22 undoubtedly had pericarditis rather than coronary thrombosis as we look back now. She has been perfectly well during the 15 years since her acute illness.

The family history, of course, is of vital importance as corroborative evidence, especially if the mother as well as the father has had early coronary heart disease or cardiovascular disease of any sort.

Mesomorphy is a helpful clue. This is inherited in large part. Mesomorphy is the body build that often is described as muscular, squat, broad; it involves an individual with broad

shoulders and short wide hands. He is an early candidate in contrast to the ectomorph of lean and linear build. After the age of fifty, however, I do not think that body build counts so much.

A high serum cholesterol reading undoubtedly is of some importance but it has got to be real high. A borderline serum cholesterol is not very important. There is a wide range of the normal in the measurement of the serum cholesterol. Coronary thrombosis may occur with either low or normal as well as with high serum cholesterol. And there may be no evidence of trouble with pretty high serum cholesterol up into the lower three hundreds milligrams per cent, but when one gets up to above three hundred and fifty or more, one certainly finds a hazard then for a much greater possibility of atherosclerosis of serious degree.

When I was in Naples, there was a Professor Malmross from Lund, Sweden, who was much interested in xanthelasma and attracted my attention particularly to it. He believes quite strongly that xanthelasma is an important corroborative clue, much more so than arcus senilis.

I have spoken of the exercise and the anoxia test. I don't suppose that in more than one case in one hundred that I see, of coronary heart disease, is it necessary to think of doing any exercise test. I always hesitate a little anyway even though one can do thousands of tests without getting into trouble. Nevertheless, every time angina pectoris is produced there is a little hazard to it. It is well, if one can, to get along without such a test, and I find that that is possible in ninety-nine out of one hundred cases.

The reaction to nitrites is an important clue. Quick clearing of the symptom by nitroglycerin, in the dosage of one one-hundredth of a grain or of one two-hundredths of a grain, is diagnostic. If in the course of a few minutes there is no improvement at all, either that patient has the pain of coronary thrombosis or else the pain is due to something other than coronary insufficiency.

The presence of a cardiac aneurysm by X-ray,

of course, means an old infarct as a rule. But then one can diagnose such a case without the need of the X-ray. Hence X-ray examination is not of any great importance in the diagnosis of coronary heart disease. The same may probably be said of ballistocardiography which needs much more careful follow-up study, especially of the effect of aging, before drawing final conclusions.

#### CLUES IN HYPERTENSION

Now, as to clues in hypertension. I refer to important blood pressure elevation, not to blood pressures that are borderline. We see many cases that do well with hypertension of slight to moderate degree; I am not referring to that group but to the important degrees of hypertension. The importance of hypertension is shown by its effect on the heart, on the kidneys, and on the brain. Naturally if you have a patient with even slight or moderate hypertension and a cerebral vascular accident, there is probably some relationship to the hypertension therein, although the cerebral vessels and other peripheral vessels may also play a major role.

The inheritance of tissue is undoubtedly important. Many persons inherit arteries that can stand high pressure for many years. Others inherit arteries that can't stand the wear and tear, whether of hypertension or of other things. Thus there is a great variation in the effects, which can be sometimes seen in symptoms of encephalopathy or in changes in the electrocardiogram. It is very important to follow every patient with hypertension even those with not very high levels, at least annually, by electrocardiograms because of the fact that the first evidence of the effect of the strain on the heart is beginning enlargement of the heart and this is shown in the electrocardiogram as a rule long before there are any symptoms or even X-ray evidence.

Electrocardiographic Lead 1 and the chest leads over the left ventricle, especially V5, show a sinking of the T waves long before there is any inversion and before there is much left axis

deviation or much left ventricular enlargement. X-ray study of the heart is as a rule a much cruder, less sensitive test of the effect of hypertension.

The X-ray picture of the aorta in hypertension is of some importance. The aorta may show tortuosity and sclerosis, indicating an effect that may be partly hypertensive, particularly when there have been high, diastolic levels.

Patients who consistently show high diastolic levels have a serious type of hypertension which demands usually some radical treatment. About ten per cent of my patients with hypertension are serious cases. I would, therefore, for that ten per cent, substitute more radical treatment which would consist either in sympathectomy in a properly selected patient, in strict dieting, or in carefully using the new "hypotensive" drugs. I still advise Smithwick's sympathectomy in patients whose diastolic pressures are high with pulse pressures not very high and who as a rule are males between 35 and 50; their hearts may or may not already show evidence of trouble but their renal function should be reasonably good.

We now have drugs for hypertension that are fairly effective, but it is so difficult to maintain in some cases a proper level of blood pressure by drugs over years, when there are a good many years ahead, that it is sometimes well to go ahead and do the radical procedure of sympathectomy and get it over with. I have a good many patients who are quite well and have close to normal pressure with postural drop in pressure even today, ten years after Smithwick did their sympathectomy. I'm sure that I have seen many patients whose lives have been saved or prolonged by sympathectomy. The operation is a nice thing to avoid if possible, but so is the rice diet or any very severe diet low in salt. I am sure some limitation of salt is very desirable, but it is very difficult to carry on for many years on a very rigid no-salt treatment.

The use of drugs is fascinating, of course, and now with the combined use of various drugs one

can, especially in patients who are older or not suitable for these other measures, do a reasonably good job in controlling the blood pressure.

It is very important to get serial blood pressure and electrocardiographic records at least yearly in cases of hypertension. I should have mentioned that also with reference to coronary heart disease. It may be necessary to take daily electrocardiograms in suspected coronary thrombosis including the twelve leads or even more. Daily records for a week may be relatively normal before the changes appear. And so in the case of blood pressure studies, I am sure that it is very important to take records of the blood pressure or have them taken at home by the family of patients whose blood pressure may seem to be much too high in the doctor's office. I, myself, am sometimes more of a pressor agent than is ice water. In my own office, a patient enters wondering what pressure I'll find, and what I may say about it. This apprehension can send the systolic pressure up twenty, thirty, or even forty millimeters. Yet that may be the only time in the day, the only time in the week when that patient's blood pressure is so high as that. Therefore it is well to know what the basal pressure is at home as well as the pressure under stimulating circumstances, whether you use ice water or anything else such as a cigarette. The more pressures you can take, the better, avoiding of course making a neurotic of the patient, and with his full understanding. The more pressures you take day and night over a period of a few weeks, the better idea you will have of what the average pressure is in that given individual. If the pressure stays high with a diastolic reading of 120 or more millimeters at rest at home, then the patient is in for trouble. But if the diastolic pressure is 120 only in the doctor's office and gets down to reasonable levels at home for most of the rest of the day, we don't need to be so worried.

There has been too much attention paid to a few records under pressure agents and too much attention similarly paid to just the basal pres-

sures. The truth is between these two extremes. We should know both extremes and thus more or less the average between them.

#### CLUES IN RHEUMATIC HEART DISEASE

Just a word about rheumatic heart disease. Do we have conclusive clues of activity of rheumatism? When is rheumatism active?

Now we are getting evidence of such activity from the biopsies of the atrial appendage, and we find many patients who have seemed perfectly well so far as any infectious process is concerned, but who, while having their mitral stenosis repaired show Aschoff bodies in their atrial myocardium. What does that mean? Undoubtedly it means that there is a much greater chronicity of the active process than we have ever realized before. I think that about fifty per cent of those biopsies that have been reported here and there have shown activity even when there has been no other evidence whatsoever of activity.

Therefore, I think that we must regard more conservatively the probability of a constantly active process, very mild but which may be going ahead slowly to produce a mitral stenosis that may be quite tight at the age of thirty-five, while during the previous fifteen years there has been no evidence of any particular episode. Probably in many cases there is almost a constant very mild activity of the rheumatic process, with flareups when the patient is exposed to the hemolytic streptococcus. I suppose that the present programs that have been started, constantly to give penicillin, are the best answer. We are now tending to give penicillin all the time, even for years to these youngsters who have rheumatic heart disease and who are being followed. That may protect them.

I saw a little boy this morning in the clinic in Boston, whom I first saw a year ago when he was six years old. He is now seven. He had a grade three apical systolic murmur a year ago due apparently to active rheumatism; he was having nosebleeds then, but he didn't have any

arthritis. That murmur was the most important clue of all to the diagnosis of rheumatic fever and of rheumatic heart disease. The heart alone may afford the only clue to activity of the rheumatic process. Of course at the same time we should carefully avoid making these youngsters too heart conscious. Nevertheless it is important to follow their heart murmurs very carefully. He was put on penicillin last summer and has been on it ever since. His murmur today was only grade 1+ and he was in excellent health. His sister had scarlet fever a month ago, but he escaped. It does look as if the penicillin in his case were having a favorable influence.

We haven't any absolutely specific clue to activity of the rheumatic process but the cardiac examination is often revealing. Murmurs in many youngsters come and go, due to the temporary effect of the rheumatic process on the myocardium with dilatation of the mitral ring and not to valvular disease.

Again family inheritance and heredity come in. Family susceptibility to the reaction to the hemolytic streptococcus is another important clue.

Now as to climate, we found a lot of rheumatic heart disease in Naples recently. Southern Italy, I can assure you in early March does not have warm weather. It can be very rough. We ourselves had hail storms there this year, much rain and wind, and very little sun. By the end of March or early April, spring begins but not in early March. Naples does not have a suitable climate for anybody who is likely to have rheumatic fever or bronchitis. The houses of the poor people or even many of those of moderate circumstances are not heated. Most of the pensiones aren't heated. In fact we had planned to live in a pensione but we had to give that up because there was no heat in it. We finally went to a small hotel where there was a little heat. Many Neapolitans are crowded together in cold basement rooms, sometimes three or four or more in a room. They build a little bonfire out-

side, in front, to warm their hands. That is about all the heat they have.

The three diseases which we found most common in Naples in our recent survey included first, bronchitis, acute and chronic. When we went through the wards in the hospitals we heard many patients wheezing. In nearly every other bed there was an acute or chronic bronchitic, either male or female. I think that this is due again to the climate, and the passage of organisms back and forth, and the inability to obtain proper heat. The patients sometime wore three or four suits of underwear in bed, even in the hospital wards.

The second disease we saw commonly in Naples was nephritis, acute and chronic nephritis. I suppose that this was for the same reason.

The third was probably rheumatic fever and rheumatic heart disease. We didn't however see some of the diseases which used to be common. Even there in Naples they are uncommon now: typhoid fever and dysentery and syphilis. I saw only five cases of cardiovascular syphilis in nearly four hundred bed patients. It used to be much more common. So that, too, is now pretty well under control.

#### CLUES IN CONGESTIVE HEART FAILURE

Congestive heart failure is a very important condition with which most of you are quite familiar. But I would like to emphasize certain clues. In the first place there is always a factor of strain. You don't see congestive heart failure come out of a clear sky. Once in a while it is hard to tell why a patient may have had heart failure, but if you happen to see him at the time of the acute process, you may find some such causative factor as extreme paroxysmal tachycardia. You may find a heart rate of 250 or more which may be past history by the time the doctor gets there. And there may be pulmonary embolism or something of that sort that will cause in some persons, especially in older patients, heart failure without much to find be-

tween attacks. Usually, however, there is a mechanical defect or strain evident, either involving the left ventricle, such as aortic stenosis, for example, or hypertension, or a myocardial infarct of large size, or involving the right ventricle, such as mitral stenosis. I might add that the cor pulmonale was occasionally diagnosed in Naples in persons who had had chronic bronchitis for many years; I suppose that their right ventricles might be somewhat enlarged, but I doubted many of the diagnoses, since the electrocardiogram didn't show in most cases right ventricular enlargement though it did so in a few. There is no reason why they shouldn't have some cor pulmonale from their chronic bronchial disease, but high degrees of such a condition were not common.

In nearly every case of congestive heart failure the heart is enlarged. In ninety-nine per cent, I would think, of the patients I have seen who have had congestive heart failure there has been enlargement of the heart. It may not be very marked and it may come and go, since there can be a considerable difference in heart size from time to time.

The symptom of orthopnea at night is a very important clue and may give rise to insomnia. I want to emphasize the fact that insomnia in a patient who has a factor of left ventricular strain, may be an important clue to pulmonary congestion. If a patient cannot sleep, he may or may not be able at first to tell why. He may not realize that he is short of breath but he gets up and paces the room; he is restless, he wants to sit up, and he sleeps better in a chair. Always suspect the possibility of pulmonary congestion in sleepless cardiac patients. Early congestive failure may not show any edema, of course. In such a case it may be well to use therapeutic tests with digitalis, low salt intake, or even diuretics on occasion, and you may have remarkable recoveries from insomnia.

One patient whom I saw years ago was actually psychotic, unable to sleep, very very restless and about to be put into a sanatorium.

He had been given large doses of hypnotics which occasioned some of the psychosis. But when we changed and gave him digitalis and a mercurial diuretic, he needed neither hypnotics nor a sanatorium. Cough can sometimes be a clue to pulmonary congestion, but it is not a common one.

Then come the physical signs. Long before generalized edema appears, before the liver is engorged and the neck veins swell, one may find gallop rhythm, accentuation of the pulmonary second sound, and pulsus alternans, especially in a hypertensive patient. Those three signs are very important evidence of a failing left ventricle, and they demand treatment: rest, digitalis, limited salt intake, and if necessary diuretics. You may not need to give diuretics. Sometimes that is overdone nowadays. You may get along very well with rest and digitalis in most of these patients. But when you find pulsus alternans and gallop rhythm, don't wait till you get more clear evidence of congestion. Go ahead and treat to prevent congestion. Engorgement of the neck veins is late evidence of failure in most cases.

#### CLUES TO PULMONARY EMBOLISM

I do want to add a word about pulmonary embolism because that is often a very striking disease. It was not recognized in most medical patients when I first started practice, and really not very much until about twenty years ago when suddenly some of us became aware that pulmonary embolism in the medical wards was common, more common even than in the surgical wards postoperatively or obstetrically after delivery. It was wrongly called hypostatic pneumonia or an increase of congestive failure. Of course the clues were quite clear as we see them now. A sudden rise in temperature, not necessarily very great, an attack of dyspnea, sometimes anterior chest oppression, and particularly tachycardia, sinus tachycardia: those three things with all curves going up abruptly should make one think of pulmonary embolism,

especially in a bed patient. There may be no sign of phlebitis in the legs. Such a patient should be observed carefully for the probability of pulmonary embolism complicating heart failure or complicating anything else that keeps him in bed a long time. Sometimes there is sweating with pulmonary embolism. The process comes abruptly in contrast to the way infection starts or an increase in congestive failure develops. Then there are clues to pulmonary embolism once in a while in the electrocardiogram. About ten per cent of patients who have pulmonary embolism show evidence of the acute cor pulmonale in the electrocardiogram; these usually have massive emboli, with dilatation of the right ventricle.

#### CLUES TO NEUROCIRCULATORY ASTHENIA (NCA)

Now a word about neurocirculatory asthenia. Many of my patients who have shown symptoms of neurocirculatory asthenia are worried about their hearts. Others have simply cardiac neurosis, anxiety without any symptoms therefrom, because some friend has died suddenly. They are nervously worried but they aren't sighing, and they don't have a lot of palpitation and weakness in the way that the neurocirculatory asthenic patient has. Thus there is a difference between the two. The more symptoms as a rule, the less disease, unless this should be called a disease as I think it should. Neurocirculatory asthenia is after all a lack of ease but it is comforting in talking with such patients to find that they admit more and more symptomatology. In fact they admit it often before you ask them. They come in sighing and tell about their disagreeable heartache with tenderness on pressure, their palpitation and their faintness. And then there are symptoms of nervousness too. The more symptoms the less organic heart disease as a rule, although heart disease may be tacked on to NCA. You can tell him or her, and it is a little more often her than him, that careful follow-up studies have indicated that patients

with neurocirculatory asthenia survive longer than the average person. That we have proved pretty well by a long follow-up of 171 cases. They may or may not acquire other diseases but very few of them get coronary heart disease.

#### A CLUE TO COARCTATION OF THE AORTA

In the case of coarctation of the aorta, I'd like to mention one clue. I find that it is very helpful to listen carefully over the spine because you may find there the first and at times only good clue in the form of a moderately loud systolic or continuous murmur down the spine when you hear almost nothing abnormal in front in a young patient who has some hypertension. Therefore listen carefully along the spine and every now and then you will be able to make a clearcut diagnosis by finding that murmur.

#### HEART RATE IN ATRIAL FIBRILLATION

Not infrequently in cases with atrial fibrillation, the heart rate is difficult to control by digitalis or rest, unless you give massive doses. Sometimes you have to give three or four times the average dose of digitalis in order to control the heart rate. Don't hesitate to give large doses of digitalis after you have tried smaller ones. I have a number of patients now who have been taking three or four average doses every day for years in order to maintain a heart rate of 75. While some patients need only one grain or a tenth of a gram a day, others will need three or four-tenths of a gram every day of digitalis leaf or its equivalent. If you can't control the heart rate after adequate trial for a few weeks, then you should suspect one of three or four conditions, and the three most common causes for an uncontrollable heart rate in atrial fibrillation are 1) some low-grade infection like rheumatic fever, 2) infarction such as pulmonary infarction which is not an uncommon complication in some of these patients, and 3) thyrotoxicosis. Those are the three conditions which you should especially look for in such cases.

#### EPIDEMIOLOGICAL RESEARCH IN ITALY

Now just let me have a few minutes about this adventure that I am rather full of at the moment. In this country today and in Sweden there is, of course, much concern about the very great prevalence of coronary heart disease. Myocardial infarction has become so common that we all have friends or relatives who have it, usually men, and sometimes at a rather early age. That has been well advertised the country over, and hence many persons are very much alarmed about it. We have a right to be concerned because we don't seem to be doing much about it. The same concern exists in Sweden.

Professor Malmross of Lund, Sweden, Professor Biörck of Malmö, Dr. Joe Doyle of Albany, and I joined, as a clinical team, Professor Ancel Keys from Minneapolis and his biochemical and physiological team in a study in Naples and Bologna in February and March of this year. We are just back from it. We haven't got the data all analyzed yet, but the reason we went to Naples is that we had heard that there was not much coronary heart disease in Naples. Was this true, and if so, why? Those were the two questions.

Having the entré to the medical school in Naples through a young biochemist who had worked with him in Minnesota, Professor Ancel Keys had the run of the biochemical laboratories for his research. Dr. Keys took over with him a small team, including his wife, who is a biochemist, and a statistician, an actuary in one of the insurance companies in Minneapolis; there were also several others: a capable young biochemist from Yugoslavia, Swahn from Lund, Sweden, who had just introduced a new paper chromatographic test for the lipoproteins, alpha and beta, a young biochemist named Bronte-Stewart from South Africa, an Australian, and several young Italian doctors.

These two teams, clinical and biochemical, joined forces to make this study in Naples. Dr. Keys in early February began a study of the

serum lipids, body measurements, and electrocardiograms of typical Neapolitans, who included first, 130 heavy workers in the Ilva steel mills in Naples, second, 150 city firemen, the Vigili del Fuoco, of Naples, who have a certain amount of drill and a fair amount of exercise, but who do not work physically as hard as the steel workers, and third, about 75 clerical workers under city employ. All were much the same type of person and lived alike except for the degree of physical activity which was different for the three groups. They had much the same scale of living and ate the same type of diet which I might add is quite probably of some importance in that there is a large carbohydrate content in the Neapolitan diet, with much bread, macaroni, vegetables, and fruit, a little wine, relatively little meat or fish, some olive oil, and very little animal fat (butter, cream, eggs, and little or no pork). The blood serum was taken for cholesterol and the lipoproteins, using the same techniques that Keys and Swahn had used in Minnesota and in Sweden. Swahn came down himself from Sweden to make the tests. Electrocardiograms, physical examinations, history of diet, body build, and somatic measurements were obtained in the case of all these men.

I went to a Rotary Club Luncheon and asked for volunteers among the bankers, lawyers, doctors, and professors to be examined in the same way, and we secured quite a few volunteers. We did the same tests on them.

Then we went through the general medical wards of the hospitals and identified the patients, making notes of what diseases the patients had. We visited the different beds of the University clinics and of the Cardarelli General Hospital in Naples. We collected data on about 450 medical cases. These were average citizens, including the poor, but were not well-to-do private patients. Fearing that some might be ill at home and not seen or sent to the hospitals who might have coronary heart disease, we arranged with the city health department to go to

the homes of the poor with the city doctors; and this we did. We found that their care was reasonably good, that there were few, if any, patients sick and dying of coronary thrombosis at home who had not been in the hospitals during their illness.

One weak spot in our Naples survey was that of pathology. There are relatively few autopsies being done at the present time in Naples. Patients leave the hospitals to die at home where there are very few autopsies. Private patients have no medical hospitals to go to. That is, the well-to-do people are sick at home and die at home. The analysis of private practice in Naples is the other weak spot except that we are now getting information from several internists who will tell us how much coronary heart disease they are seeing in their practice. Professor Matteoli, who is the most experienced cardiologist of Naples and Southern Italy and one of the ablest physicians whom I have met anywhere, is writing the second edition of his book on Myocardial Infarction based on about two thousand such patients whom he himself has seen in private practice in Southern Italy. But that is not the type of patient who is in the general medical wards of the hospitals in Naples.

Hearing that in Bologna there was more coronary heart disease than in Naples, blamed locally on the rich animal fat diet which is habitual there, and having medical friends in Bologna, who have studied with us in the States, we went to Bologna to do the same thing as in Naples so far as clinical observations were concerned, but with fewer normal individuals to be tested in the same way. Professor Ancel Keys has not yet finished the analysis of his data.

I can give you very roughly for what it is worth our findings, comparing Naples with Bologna and with Boston. On my return home, we made a census of five of the hospitals in Boston, especially of the Boston City Hospital's open wards, which would be comparable to the hospital wards in Naples. Some day we should

also go to Bari in Italy, where there is a diet especially rich in olive oil.

There is a considerable difference of opinion concerning the relationship of diet to coronary heart disease. What we need now to collect are facts. Many think that diet has nothing to do with coronary heart disease. Some think that it is physical effort, including exercise that is most important in prevention. Others think, as I have thought myself, that it is total calories that count most, since we make much of our own cholesterol. Others, including Ancel Keys, think that it may be total fat, both vegetable and animal fat. Others think that it is the animal fat alone, in particular the fat found in butter, cream, eggs, and liver.

Thus, hearing that Bologna had more coronary heart disease than Naples, we went there. Of course, it has a different climate; it is north of the Apennines, a colder climate, with spring coming about a month later. We found it so when we went there. There is clearly a richer diet which is obvious right away in the restaurants; in Bologna butter is commonly eaten, pork is a common food as are also cream and eggs. In Bari, on the other hand there is a rich vegetable oil diet, olive oil. That should be investigated some time.

This same study is planned for South Africa, to examine the Bantus, the Negroes, and the whites there, and for Sweden and for different parts of the United States. At the moment, all I can say is that in 460 beds in Naples we encountered only four or five cases of coronary heart disease, all males. In Bologna in about the same number of beds there were twenty-two cases of coronary heart disease, including females.

In a letter from Lund, Sweden, yesterday, Professor Malmross said that as soon as he got home he visited the 134 medical beds at the University clinic and found twelve cases of acute myocardial infarctions. In the Boston hospitals last week, in 532 beds there were seventy-seven cases of coronary heart disease. These figures included 45 cases among 340 pa-

tients in the Boston City Hospital. Hypertension was also more common in the Boston Hospitals, there being 88 among 500 cases compared to 30 in about the same number of beds in Naples, and 35 in Bologna. Rheumatic heart disease was much more common in Naples and Bologna, there being 41 in Naples and 39 in Bologna, while there were only 26 in the Boston hospitals. There were only five cases of cardiovascular syphilis in Naples, four in Bologna and two in Boston, both at City Hospital.

One qualifying factor, certainly of some significance, though how great it is as yet too difficult to say, is that of the ages of the patients in the medical wards in Naples, Bologna, and Boston. The difference averaged a little over ten years older in Boston than in Naples and a little less than ten years older in Boston than in Bologna; there were, however, many old patients in both Naples and Bologna. The average age of the 532 medical patients in Boston was 58 years; in Naples the average was 45 years and in Bologna, 51.\*

That is a brief summary of our clinical find-

\* Since presenting this lecture I have been able to make a correction for age in these three cities by tabulating by sex the total number of medical ward cases in each of the three decades, 40-50, 50-60, and 60-70, and also in the same decades the number of coronary heart disease cases. They were as follows:

	40-50				50-60				60-70			
	Total ward cases		Coronary cases		Total ward cases		Coronary cases		Total ward cases		Coronary cases	
	M	F	M	F	M	F	M	F	M	F	M	F
Naples .....	44	16	1	0	61	22	21	0	44	27	3	0
Bologna .....	49	54	1	1	65	43	7	0	43	43	6	3
Boston .....	38	20	8	0	62	43	9	4	66	51	13	17
Minneapolis (Veterans) ...	29	—	4	—	56	—	22	—	65	—	17	—
Total 40-70								Grand Total 40-70				
				Ward Cases				Coronary Cases				Ward Cases
				M	F	M	F	M	F	M	F	Coro- nary Cases
Naples .....	149	65	4 or 5	0	214	—	4 or 5	0	214	4 or 5	—	4 or 5
Bologna .....	157	140	14	4	297	—	14	4	297	18	—	18
Boston .....	166	114	30	21	280	—	30	21	280	51	—	51
Minneapolis .....	150	—	43	—	150	—	43	—	150	43	—	43

ings. What it may mean I don't think we can say as yet. There are many factors to consider. Race enters in, of course, but there are mixed races in both Naples and Bologna. The way of life may show itself in other respects than in diet but there is a great contrast between the well-to-do people who are members of the Rotary Club and the patients represented by the ward cases in Naples. Whether it may be worth-while for us to establish more macaroni factories in the United States and Sweden and to send our fat elsewhere it is too early to say. At any rate the fact is that we do have fairly clear evidence that something is wrong in the

United States and Sweden and we ought to do something about it. What we can do, I don't yet know. Thank you for your kind attention.

*264 Beacon Street  
Boston, Massachusetts*

DR. ANDRUS: What you have just heard, this excellent and interesting discussion comes from an authority and on an authoritative note as you know. Dr. White has, as you also know, contributed much to the study and treatment of cardiovascular diseases, and may I add also that I know quite a few doctors who have slipped out of town to see him and come back and claimed that they had his blessing of the green light.

Dr. White, we are honored to have your presence, and I have the privilege of presenting to you this honorarium from the John M. T. Finney Fund.

DR. WHITE: Thank you very much.

## SPECIAL FEATURES

### SEMIANNUAL MEETING, OCTOBER 6, 1953 NATIONAL INSTITUTES OF HEALTH, BETHESDA MARYLAND PRESENTATION OF GAVEL\*

Dr. Maurice C. Pincoffs, President, on behalf of the Medical and Chirurgical Faculty of the State of Maryland, presented to Dr. William S. Murphy, President of the Montgomery County Medical Society, a mahogany gavel with a gold band bearing the following inscription:

*Presented to the  
Montgomery County Medical Society  
In Honor of its Fiftieth Anniversary  
1903-1953  
by the  
Medical and Chirurgical Faculty of the State of Maryland  
October 6, 1953*

\* \* \* \* \*

### PRESENTATION OF GIFTS FOR THE AMERICAN MEDICAL EDUCATION FOUNDATION AND THE BUILDING FUND OF THE MEDICAL AND CHIRURGICAL FACULTY\*

Mrs. Thomas C. Webster, President,  
Woman's Auxiliary to the Baltimore City Medical Society

*Dr. Pincoffs and Members of the Medical and Chirurgical Faculty of the State of Maryland:*

It is with a great deal of pleasure and pride that at this time I can present to you, on behalf of the Woman's Auxiliary to the Baltimore City Medical Society, a check for five

\* Presented during the Scientific Session, 2:00 p.m.

hundred dollars (\$500.00) towards the New Building Fund. Also a check for a similar amount of five hundred dollars (\$500.00) as our contribution to the American Medical Education Foundation. This money was obtained through our Faculty Ball held on April 27, 1953. It was through the generous support of many of you present that I am able to present these checks today, and I hope when you receive the notice of our Faculty Ball for 1954, that you will respond in the same manner.

Thank you so very much for giving me this opportunity.

Dr. Pincoffs accepted these gifts with appreciation, on behalf of the American Medical Education Foundation and the Medical and Chirurgical Faculty.

\* \* \* \* \*

### DINNER DANCE

In the evening, the Montgomery County Medical Society entertained guests at a dinner dance given at the Congressional Country Club, Bethesda, Maryland.

## A BRIEF HISTORY OF THE MONTGOMERY COUNTY MEDICAL SOCIETY\*

J. W. BIRD, M.D.

The Montgomery County Medical Society is now well into its fiftieth year, which makes this a most appropriate time to review its history.

The first formal action toward the formation of the Society was taken on December 11, 1903, at Rockville, our county seat. Following an address on medical organization by Dr. T. A. Ashby, of Baltimore, who appeared on behalf of what the minutes refer to as the "State Society," the physicians present voted to form a permanent organization, and Dr. Roger Brooke of Sandy Spring was elected President on the fourth ballot.

The Constitution and By-Laws were approved the following April and were subscribed to by 23 physicians. Dues were fixed at \$1.00 per year, and it was decided that meetings would be held semi-annually.

Any history of an organization which has been in existence over so long a period necessarily must be based on the official minutes, which are all too

sketchy in many instances. I can say that without fear of offending anyone, because I was privileged to serve as Secretary of the Montgomery County Medical Society for 28 consecutive years—from 1920 through 1947—and there were times when it was virtually impossible for a country doctor to do full justice to that important but time-consuming job and still take care of his practice in a fast-growing community.

It was my privilege also to serve twice as President of the Society—first in 1917 and again in 1948. For the most part, our Presidents have served one-year terms, with the result that many of the County's more distinguished physicians, past and present, have filled that position.

Included in that list are two women physicians—Dr. K. A. Chapman and Dr. Naomi Lucius, who headed our Society in 1942 and 1944.

A review of the minutes of the early meetings of the Society yields a wealth of fascinating information about the medical profession and the great strides it has made in a relatively brief period. In its first years, papers were read to the Society on these important but relatively uncom-

\* Paper presented at the Semiannual Meeting, National Institutes of Health, Bethesda, Maryland, Tuesday, October 6, 1953. (Fiftieth Anniversary of the Montgomery County Medical Society.)

plicated topics: "Effects of Neurasthenia on the Eyes"; "Cases of Ectopic Pregnancy"; "Treatment of Cornial Ulcers"; and "Prevention of Minor Contagious Diseases."

Forty-five and fifty years later, the minutes record papers on "The Use of Autonomic Blocking Agents in the Management of Peripheral Vascular Disease," and "Chemotherapy of Cancer with Special Relation to the Steroid Treatment of Breast Cancer." Here we have ample evidence that life is indeed becoming more complicated each year.

Our minutes also bring to light these interesting facts and dates: The first paper read to the Society, in 1904, dealt with "Medical Ethics." The speaker was Dr. George M. Kober, ex-President of the District of Columbia Society and Dean of Georgetown Medical College.

In 1905, Dr. John S. Fulton, Secretary of the State Board of Health, appeared before the Society and recommended the establishment of special sanatoria for the treatment of TB cases.

By 1906, new members were being admitted at the rate of about 8 per year.

In 1907, the Legislative Committee was instructed to take up the question of having the State inspect the County's milk supply.

In the same year came the first mention of cancer, and the Society went on record as favoring free treatment at the Pasteur Institute of indigent patients exposed to hydrophobia.

In 1908, a committee was appointed to look into the establishment of a hospital in the County to which the Society should pledge its support. Twelve years were to elapse before that need was filled by the opening of Montgomery County General Hospital at Olney.

That same year the Legislative Committee was instructed to wait upon the County Commissioners to "try to secure 10 cents for each birth reported," and it was stated that malaria was a serious problem in Rockville.

In 1909, the year in which your speaker was admitted to membership in the Society, the minutes report that the fall meeting was held at

Takoma Sanitarium where, after dinner, the members were entertained by "nurses in uniform drilling and going through various exercises." We doubtless would encounter some difficulty in arranging similar entertainment today.

Earlier in the year, Dr. Charles Farquhar had advised taking into the Society any reputable physician, regardless of school. "We may learn something from them," he added. His sound advice has been heeded through the years.

In 1910, a resolution was approved to the effect that "This Society condemns any physician who is not in hearty sympathy with the vaccine laws."

The minutes for 1910 contain the first mention of polio. A speaker stated that 8,000 cases had been officially reported in the world, 5,000 of them in the United States. He expressed his private opinion that a total of 10,000 to 15,000 cases was more likely, and added that, "of the polio cases that do not die, 75 per cent have permanent paralysis."

In 1911, it was voted to hold a special public meeting in Kensington on the growing problem of sewage disposal and to invite the County Commissioners and the Mayors and Councilmen of all County towns.

One year later the Society was told that typhoid fever had become a national disgrace. A speaker stated that "Typhoid carriers should be regulated, but full liberty allowed provided they clean their hands and finger nails."

In 1913, the members first voted in favor of medical inspection of public schools and also endorsed the establishment of TB hospitals in the County.

In 1914, the Society voted to meet quarterly. Since 1948, we have been meeting monthly except June, July, and August.

The first mention of syphilis in the minutes appears in 1915, together with the remark that "We have a race in our midst that is being decimated by the onslaught of this disease."

The first mention of either obesity or underweight appears in 1916.

The only time the Society ever failed to meet on schedule was in October of 1918, when the minute book said, "No meeting on account of the prevalence of influenza." In January of the same year, only six members attended the semi-annual meeting of the Society.

As recently as 1926, the Society held a symposium on "The Importance of a Constructive Health Program in the County, Especially in Regard to School Children."

In 1928, appears the first emphasis on "heart conditions and the importance of proper diagnosis."

In 1933, the Society pledged support of prenatal clinics in the County.

In 1934, the Society held a discussion of Birth Control clinics, no action being taken.

In 1936, a Committee was appointed to consider the formation of a Woman's Auxiliary. Nothing came of this proposal until 11 years later, when it was voted to take immediate action. The Auxiliary, which has done splendid work in the County, finally was formed in October of 1947, with 30 ladies present. In 1942, members complained about difficulty in obtaining sufficient rationed gasoline for their routine calls on patients.

In 1943, the Society was told that the new Suburban Hospital in Bethesda was assured.

A proposal by the American Red Cross to establish a Blood Bank in the County was voted down in 1947, but then was approved 18 months later.

In 1948, our Society unanimously approved a motion to the effect that "The State Faculty should grant full membership to any qualified and licensed physician without any modifications."

I might add that the Montgomery County Medical Society follows that same principle.

In 1949, much to my personal relief, the Society voted to have a part-time, paid Secretary to take minutes and perform other secretarial duties. It also approved the establishment of a cancer detection clinic.

In the following year, the Society endorsed fluoridation of the County's water supply, the first colored physician was admitted as a "full active member," and the Society heard but did not act on a suggestion that the time had come for it to have permanent office headquarters with a full-time secretary. That suggestion was made by myself.

However, the Society did install a telephone, desk and typewriter in the home of the Secretary later that year.

At the same meeting, we approved a motion calling on the State Faculty to consult us "when appointments representing medical affairs in the County were anticipated, not after they had been made."

These are just a few of the more significant and interesting items which appear in our minutes. However, there is one other matter which has required continuing attention by the Society. I refer to the question of physicians' fees.

In 1906, the Society voted that no member should examine for a life insurance company for less than \$5.00. Then, in 1908, it was officially agreed that "Members of the Society decline to issue certificates of insanity for a fee of less than \$5.00 in each case."

In 1911, the Society heard a complaint that a member physician was charging "25 cents for office calls and \$1.00 for outside calls." The Secretary was instructed to write the under-charging physician to the effect that "such charges are not in keeping with the best interests of the profession" but that "we have no regular fee bill."

In 1917, however, the Society resolved that fees for "all office visits in towns and villages will be not less than \$1.50 each, and \$2.00 per visit up to and including 5 miles from the physician's office, with an additional fee of 50 cents per mile thereafter; that night charges be not less than twice the fee for day visits; that in obstetrical cases the fee should be not less than \$15.00 in normal cases. Any violation in the charging of

proper fees shall be reported to the Society for such action as it may deem proper."

In 1933, it was reported that baby clinics just across the District of Columbia line were drawing many Maryland Babies from private practice. A committee was appointed to investigate, but the minutes contain no subsequent mention of this problem.

In 1935, just 18 years ago, the Society unanimously approved this scale of fees: \$1.00 for office visits; \$2.00 for visits up to 3 miles and 25 cents for each additional mile, and \$25.00 for obstetrical cases.

In 1943, it was reported that a post card survey showed a vote of 35 to one in favor of a minimum fee of \$3.00 for house calls. Then, in 1948, fees of \$3.00 for office visits and \$5.00 for house calls were approved.

In this connection, it is interesting to note that, in 1935, after approving the action of the State Faculty in deciding to treat indigent patients without compensation, the Montgomery County Medical Society appointed a Committee to study the care of indigent patients.

Two years later a Committee was appointed to present to the County Commissioners a plan for having the County compensate physicians for the care of such patients.

A year later in 1938, after a sampling survey had been conducted, the Society voted to ask the Commissioners to budget \$11,650 a year to reimburse physicians for the medical care of indigent patients.

The next and the last mention of that proposal to appear in the minutes was in 1941—six years after the idea first was discussed—when the Committee on Care of Indigent Patients was continued and was instructed to meet again with the Commissioners.

The Society appears never to have suffered any really serious financial problems. In fact, in 1905, after a favorable report by the Treasurer, with dues still at \$1.00 per year, the members voted themselves a dinner at the expense of the Society. In the spring of 1908, the treasurer re-

ported that all dues were paid in full but added that the treasury was about exhausted.

In 1911, there was \$64.44 in the treasury, but by 1948 there was \$2,373 on hand.

Our membership has grown steadily from the original 23 to the point where it now numbers about 250, including associate members.

As recently as 1947, a survey showed only 88 physicians practicing in the County, 66 in the metropolitan area near the District and 22 in the upper County.

Thus, the major part of the increase has come in the last few years and today, I assure you, there is no shortage of competent physicians in Montgomery County.

Part of our recent increase in membership has been due to expansion in the medical staff at Walter Reed Hospital just over the line in the District of Columbia and to the establishment of the Navy Medical Center and the National Institutes of Health in Bethesda.

The Society has 8 standing committees:

1. Program and Scientific Work
2. Judiciary
3. Public Health and Legislation
4. Public Relations
5. Medical Relations
6. Medical Defense
7. Cancer
8. Diabetic Detection

I desire to report in detail the general plan of two of the Committees.

**First**—The Committee of Public Health of which Dr. Robert A. Bier is Chairman. This Committee, as the name implies, is vitally interested in the health of the community and acts as the liaison between the Society and the County Health Department. This is an important committee, as it also concerns itself with the work and the scope of the Health Department in its relation to the private physician and private practice, a very volatile and active subject these days.

The Public Health Committee has studied problems and has collaborated with the Health

Department in several programs. The following are some of the recent projects worked out by the Public Health Committee and the Health Department: Examination and immunization of children by the private physician prior to entering school, examination of high school athletes by private physicians, limiting the admission to the County Clinics to those persons unable to pay for private medical services, and more recently, considering the problem of unfettered dogs attacking children.

There has been an unusually harmonious and cooperative relationship between the Medical Society and the County Health Department which has been of mutual benefit to the Society.

**Second**—The Public Relations Committee of which Dr. Charles I. Warfield is Chairman and who is responsible for the plan of the Montgomery County Medical Bureau established in June 1952.

1. This Bureau acts as a clearing house for all calls for the Montgomery County Medical Society and handles all the messages for its secretary.

2. It has a complete file on every physician who is a member (active, associate, affiliate, etc.), of the Medical Society, and lists their office addresses, phone numbers, specialty, hospital affiliation, hours and appointments and specialty training, etc.

3. A referral service is worked on a rotation basis. When a patient calls asking for a specialist or a general practitioner they are given three names in that category, whom they may call. These three names are then rotated to the back of the list and the system continues perpetually in this manner.

Physicians are also divided into particular localities (Silver Spring, Bethesda, Sandy Spring, etc.).

4. In July 1952, the Medical Society unanimously backed a compulsory emergency call program. Emergency calls were limited strictly to calls from fire rescue squads, or police at the scene who needed the services of a physician

before a patient could be moved to a hospital. The emergency system was divided into five areas (Silver Spring, Takoma Park, Bethesda, Rockville and Upper County). There is one man on emergency call for each of these areas each twenty-four hours. This is on an alphabetical rotation basis. The physician on emergency call in each area is notified twenty-four hours in advance, previous to his tour of duty by the medical bureau. Every physician, regardless of specialty, is included in this plan.

5. In addition, the Bureau has an alternate listing service for physicians whereby physicians may list in the phone book after their number, "if no answer call" such and such a number.

6. Every call to the bureau is recorded as to the person, nature of the call, stamped by the time clock as to time, and dispensation of the call. All these slips are then sent to Dr. Warfield for review, so that the function of the board remains at its highest standard.

7. The Medical Bureau also handles direct lines from the office of doctors. When the bureau began there were ten such lines. There are now, at the last counting, fifty-eight lines.

Our Society has, I believe, exercised a great deal of intelligent leadership in the County in matters of health and public welfare. We have endeavored to extend full cooperation whenever called on for help and advice and, in turn, we have received splendid cooperation from other County groups.

There has been a high degree of harmony in our ranks and we have been entirely free of factions. There have been few serious problems of ethics and few occasions for discipline. I believe we have the full respect of the community.

The Montgomery County Medical Society has produced two presidents of the State Faculty, a delegate to the American Medical Association, and two members to the State Board of Health. It has been my privilege to have been selected for several of those assignments. One of our members served two terms in the Maryland Senate, and another served two terms in the House of

Delegates. In addition, a member of our Society was nominated for the General Practitioner's Award of the A. M. A.

On two occasions, in 1916 and again in 1946, we had the honor of entertaining the State Faculty in our County. Some 30 physicians from Baltimore and other parts of Maryland have addressed our Society during these 50 years.

I think you can rest assured, on the basis of

our past record, that the Montgomery County Medical Society in the next 50 years will maintain the same progressive spirit and the same high degree of service that have marked this first half-century. I have every confidence that we will. It has been a real pleasure to present this brief history to you, and I hope it places our Society in a good light. Thank you very much.

*Sandy Spring, Maryland*

## MEDICAL RESEARCH, THE PHYSICIAN, AND PUBLIC HEALTH<sup>1</sup>

LEONARD A. SCHEELE, M.D.<sup>2</sup>

It is a real pleasure to welcome to the Clinical Center these two "ancient and honorable" associations—the Medical and Chirurgical Faculty of Maryland and the Montgomery County Medical Society. We in the Public Health Service are glad you chose the Center for this special meeting, because in doing so you claim this institution for your own. And so it is—just as it belongs to the medical community across the country. As a Federal institution, the Clinical Center exists to perform a public mission—even though the nature of the mission is highly specialized.

Because of its location, we feel—and we hope you share this feeling—that the physicians of Maryland, especially those of Montgomery County and other parts of the Greater National Capital Area, have a greater than average interest in the Center and a concern that all we do here shall come up to the expectations of scientific medicine. In the years, we in the Public Health Service intend to do all in our power to strengthen the bonds of cooperation

which have been forged with you and your professional organizations today.

I understand that immediately following this session, you will have an opportunity to inspect the Center. I have no wish to delay you, so I will take just a few minutes of your time to discuss a relationship that has brought the Clinical Center into being: that is the relationship of medical research, the physician, and public health.

Sir MacFarlane Burnet, Director of Australia's Hall Institute of Medical Research, says in a recent paper (1): "The aim of medicine in the broadest sense is to provide for every human being . . . the greatest fullness of health and length of life that is allowed by his genetic constitution and by the accidents of life." A natural corollary of such a statement of purpose is that the aim of medical research is to produce the knowledge wherewith medicine can help the human race achieve that high level of health and longevity.

Up until the past two or three decades, the two main areas of medical research were infectious diseases and surgery. In the past 80 years, we have attained a truly inspiring victory over the major infections. Surgical treatment has been extended beyond the highest hopes of

<sup>1</sup> I. Ridgeway Trimble Fund Lecture, Semiannual Meeting, Medical and Chirurgical Faculty of the State of Maryland, held at the Clinical Center (NIH) of the Public Health Service, Bethesda, Maryland, October 6, 1953, at 2:00 p.m.

<sup>2</sup> Surgeon General, Public Health Service, U. S. Department of Health, Education, and Welfare, Washington, D. C.

Lister and his contemporaries. To these signal contributions must be added improvements in human nutrition and advances in the means for compensating poor eyesight, loss of hearing, and other functional impairments.

One result of scientific and technical progress in these fields is that the physician and public health workers today have at their command the knowledge, the skills, and the armament to combat successfully a vast range of diseases and physical defects which a century ago were inaccessible to medical, surgical, or environmental control. A second result is that an even wider range of diseases and congenital defects, over which we have little or no control, now affect larger numbers of people than do the conditions for which we do have controls.

The family physician of today, for example, may see a great many patients each year with cardiovascular diseases, cancer, arthritis, diabetes, and similar chronic diseases, whereas he may go through his entire practice without seeing a single case of malaria or typhoid fever. A significant proportion of his patients will present mental disorders or physical defects of psychic origin. By appropriate immunizations, he will have protected his child patients from diphtheria, whooping cough, and tetanus; but for the infant born with retroental fibroplasia, he can do nothing.

His colleague, the public health officer, likewise will watch the death rates from heart disease, cancer, and cerebral hemorrhage rise year by year in his community, while there will not be a single case of malaria or typhoid fever. Moreover, he will be disturbed by the increasing numbers of people from his community who are being committed to public mental institutions. His co-workers in the public welfare department, the school department, the county court, will be seeking his advice on how to handle the community's growing burden of dependency due to long-term illness, of juvenile delinquency, alcoholism, and so on.

It is the mission of medical research today—

of this Clinical Center—to give the physician and public health the answers to their dilemma—the dilemma of knowing how to deal successfully with conditions that are progressively decreasing, and not knowing how to deal with those that are progressively increasing.

The chronic diseases and congenital defects with which we must deal today call for major advances in clinical research, integrated with major advances in basic research. It is safe to say that the task is a far more formidable one than that presented to medical research by the infectious diseases 50 years ago. Once the basic principles of bacteriology and immunology had been established, and research techniques developed, it was relatively easy to achieve rapid progress, with relatively little clinical research. In chronic disease and mental illness, however, the research problems are different. To quote Burnet again: "They are complex and difficult to understand; they can be reproduced in animals only in rather crudely and distantly analogous forms—and at the present time there is virtually nothing we can do to prevent their occurrence. There is no short cut to their understanding via the laboratory bench; they can be tackled only by the direct study of human material. These are the problems that medical research must face in the future—and we may have to make considerable reorientation of our idea of medical research to do so (2)."

We feel that the Clinical Center will give us the opportunity to make such a reorientation. Here we expect to integrate laboratory studies, that are probing deeper and deeper into the living cell, with clinical studies of cancer. Here we expect to bring all the resources of biochemistry, biophysics, physiology, and related disciplines to bear upon the clinical problems of cardiovascular, metabolic, and neurological diseases. Here we expect to pursue a coordinated approach to the problems of mental disease. Here we expect to extend our understanding of virus diseases and the relationship of allergic responses to micro-organisms, as manifested in

such widely occurring conditions as rheumatic fever.

I know of no responsible investigators who believe that medical research can produce complete answers to any or all aspects of the chronic diseases within a few years time. However, the expansion of medical research in these fields since World War II has produced within a decade some results so encouraging as to give hope for major progress in some important sectors within the next 10 to 25 years. For example, the possibilities of improved diagnostic aids and chemotherapy in some types of cancer are great. Also, many authorities are confident that within a quarter of a century, medicine will have the means to master much, if not all of the untimely death and disability due to the major types of heart disease.

We expect that, with the cooperation of the medical profession and other research institutions, the Clinical Center will contribute an honorable share to these potential advances. We have more than a professional and scientific interest in making our full contribution to the solution of these problems. For the Center is here, and its combined research and medical service staffs are here in answer to the deep desire of the American people to be rid of these latter-day plagues—if such freedom can be won through medical research.

The Congressional Hearings being conducted at the present time, under the leadership of Congressman Charles A. Wolverton of New Jersey, are a reflection of the keen public interest in these health problems and their solution. It should be a matter of satisfaction to all of us that the discussions to date have revealed a solid front of cooperation among public and private groups concerned with medical research and the Nation's health.

We in the Public Health Service, as well as the private physicians and their organizations, must never lose sight of the public demand for progress against these costly and catastrophic diseases. A facility and an organization of the

Center's size and complexity is somewhat overpowering. Medical research today takes on some of the aspects of big business—whether it is conducted by a university, a foundation, an industry, or a governmental agency. The new research techniques, the new approaches to the problems which need solving, however, require facilities, equipment, supplies, and a variety of skills entirely beyond the reach of the individual scientist. In the Clinical Center, you will see research tools that need highly trained scientists simply to calibrate and utilize them. Contemporary standards for the care of patients are entirely different from those of twenty or even ten years ago.

Dr. Detlev Bronk, former President of Johns Hopkins University and the recently appointed Director of the Rockefeller Institute of Medical Research, has expressed a concern which he and many other research administrators share, lest the potential dangers of "bigness," of specialization, impair the creative force in scientific inquiry. "Scientists," he says, "whose knowledge is narrowly restricted are hampered in their research; they are unfit to form new facts in conceptual schemes . . . Modern universities all too frequently give the scientist of the future the bare bones of science, unarticulated and unclothed with the flesh of meaning—a wealth of knowledge but of a single field of science, little of related fields, and no view at all of the broad sweep of intellectual adventure through the ages (3)."

The problem for all of us in the Public Health Service, and specifically in the Clinical Center, is to surmount the threat of hampering influences. I do not share the feeling of some people that great hardship in research produces great discoveries. No, only great minds, great souls produce great discoveries. Symbolically, therefore, the Center itself challenges us to be giants—in mind and soul.

It would seem unlikely that an institution to which, eventually, almost 500 patients and their families will bring life's most poignant experi-

ences, can get out of touch with reality. And yet, it is possible in an environment more isolated than the university campus, more sharply focused on a specific way of thinking, more susceptible to narrow concepts of the aim of medical research—that this great part of the Public Health Service could lose touch with the broad aims and day-to-day problems of medicine and public health.

We are indeed fortunate to have the physicians and public health agencies of the Nation to be our friends and critics. For, while we may here pursue well-designed studies and learn the ways of team-work with our colleagues in many basic and clinical disciplines, we need always the active participation of physicians and public health officers to guide our thinking and research effort.

It is our hope that the research done here, in turn, will produce findings that the physician and the public health officer can apply in their particular spheres to the control of chronic diseases and mental illness. Dr. Vlado A. Getting in an address (4) at the Annual Session of the American Medical Association last June, pointed out that "The family physician is more than ever before in the front line of preventive medicine and health maintenance. He has an unusual opportunity to be of service to his patients and through them, to the community as a whole . . . The health department attempts to provide services to the community that cannot be provided by the family physician."

At the present time, both family physicians and public health officers are seeking more effective means to deal with the tremendous burden of chronic disease and dependency due to ill-health—on the one hand, in their patients and on the other, in the community.

For the future in chronic disease control, we can say that medical research has attained new heights in the level of scientific understanding—and will attain higher levels if the current programs are continued. While the public awaits additional answers from research institutions, physicians, hospital staffs, and public health officers must join in an exploration of new roads to cooperative services. In doing so, these front-line workers can undoubtedly contribute to the medical research effort by careful trial of new techniques, by the follow-up of research patients, and by reporting all they can learn about the early stages of these diseases. The family physician, the local hospital, and often the industrial physician and the health officer, are far more likely to see early cases than are the specialists and the research institutions.

Here at the Center we hope to have many private physicians, hospitals, and public health departments participating in our research programs. I am sure that this type of cooperation will ultimately enable American medicine to achieve its broad aims of "fullness of health and length of life" for every person—even in the face of the rising tide of chronic disease and mental illness.

*Department of Health, Education, and Welfare  
Public Health Service  
Washington 25, D. C.*

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## Reports

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### COMMITTEE FOR THE STUDY OF PELVIC CANCER

BEVERLEY C. COMPTON, M.D.\*

The Committee for the Study of Pelvic Cancer meets in the Medical and Chirurgical Faculty Building on the third Thursday of each month, September-June, from 5-6 P.M.

#### *Abstracts of Case Discussions:*

Case I. M. P. White. Age: 30 years. Married. Para 1. Beginning in January 1952, menstrual periods completely irregular—intermittent bleeding varying from faint pink spotting to a gush of bright red blood. Also at this time abdominal pain extending from mid-line to lower right quadrant. Consulted doctor A in early February—oral medication prescribed and patient told that symptoms were probably due to the fact that she had to be on her feet constantly while at work. Consulted doctor A every week or two over a period of several weeks. Beginning in March, continuous, profuse yellowish vaginal discharge of foul odor. Consulted doctor B in late April—was examined and told that she had "trouble with womb." Rx. Douches. In June, three episodes of profuse bleeding. Doctor B referred the patient to the hospital clinic about June 15th. Patient hospitalized June 25th.

*Diagnosis:* Squamous cell carcinoma, cervix, I. C. III.

*Treatment:* Radium and deep x-ray therapy.

*Chairman:* For the benefit of those who are attending these meetings for the first time, I would like to say that the purpose of this Committee in reviewing cases of pelvic cancer is to attempt to reduce delay periods in diagnosis and treatment. The objective is educational and not critical. We hope that the discussion of cases may be of benefit to all physicians. In reviewing cases we classify them as patient delay, physician delay or institutional delay. We consider a time lapse of more than one month as delay.

In this particular case we cannot say definitely as to patient delay because we do not know the exact dates of the onset of symptoms or of the first medical consultation. There appears to have been treatment delay on the part of both physicians. Is there any comment on this case?

\* Secretary. Under the auspices of the Medical and Chirurgical Faculty and the Maryland Division of the American Cancer Society.

*Visiting surgeon:* This case was treated at our hospital. The history is substantially as given in the abstract. Our records indicate consultation with doctor A but note that a pelvic examination was not made by this physician. Doctor B was consulted on the 3rd, 6th and 10th of May and a pelvic examination was made on the 10th with the diagnosis of cervicitis and salpingitis. He referred the patient to our clinic about the 19th of June when she was bleeding profusely. She was admitted to the hospital on June 25th and diagnosed as Stage 3 or possibly 4.

*Chairman:* The delay in this case between February and June might mean the difference between curable and incurable cancer.

*Visiting surgeon:* We considered it advisable in this case to treat the patient with x-ray first and then re-admit her to the hospital for examination and re-evaluation before radium. We did give the radium but at that time there appeared to be a mass extending into the rectum.

Dr. Scheffey and Dr. McKelvey have advocated x-ray routinely before radium. I would like to ask for an opinion on that.

*Chairman:* In the case of a big, sloughing ulcerative lesion with infection it is often wise to try to disseminate the infection and shrink the mass with x-ray.

There was considerable discussion of this matter.

*Visiting surgeon:* Incidentally, the Papanicolaou smear on this patient following irradiation, showed atrophic cells.

There was discussion of the value of Papanicolaou smears following irradiation. The consensus was that a positive smear might indicate that the tumor is resistant, but many false negatives are obtained, indicating only that the local lesion is atrophic. The studies made by Dr. Meigs and Mrs. Graham were cited. It was emphasized that the work of Mrs. Graham has dealt particularly with the radiation reaction of normal cells—i.e., a certain reaction in normal cells will indicate whether or not a tumor will be radio-sensitive. The figures from this study were thought to be impressive.

**Case II.** M. B. White. Age: 33 years. Married. Para 1. Right ovarian cyst removed in 1951. In April, 1953, considerable abdominal discomfort and yellow vaginal discharge. No menstrual irregularity. Consulted doctor A in early May—pelvic examination made—patient told that she had an ulcer and the lesion was treated with local applications. She remained under the care of doctor A until referred to the hospital clinic in early July. Following examination the impression was that the lesion was benign, possibly caused by the application of a strong chemical. Rx. Aureomycin suppositories and astringent vaginal douche. Patient returned to the clinic two or three times—no improvement—hospitalized for biopsy September 3rd. (Serology found to be positive at this time.) At the time of biopsy the tentative diagnosis was tertiary syphilitic ulcer of the vaginal vault; chronic cervicitis. The pathological report: Papilloma of the vagina, beginning squamous cell carcinomatous change in vaginal wall; chronic cervicitis. Patient re-admitted on September 21st for diagnostic D. & C. and multiple punch biopsies of the cervix and ulcer of vaginal vault. Referred to second hospital for treatment September 29th.

*Diagnosis:* Primary carcinoma of the vagina.

*Treatment:* Radium and deep x-ray therapy.

**Committee member:** Very often we do not know why there is delay on the part of the physician or institution. In this case, I saw the patient when she first came to the hospital clinic and failed to realize that we were dealing with a carcinoma of the vaginal vault. The gross lesion appeared to be a superficial ulcer with considerable secondary infection. After clearing up the infection, the patient improved clinically but the lesion itself did not show improvement. I did not see the patient following her first visit to the clinic because I was away. I feel the house staff should be congratulated that they realized the lesion should be biopsied and sent the patient in to the hospital. The biopsy finding is as given on the discussion sheet. All of us were surprised to find that we were dealing with a primary carcinoma of the vagina. The lesion appeared to be confined to the right lateral vaginal vault. The biopsies of the cervix taken at the time the patient was re-admitted for D. & C. were negative.

**Visiting surgeon:** The biopsy taken at the time this patient was admitted to the second hospital for treatment did not show carcinoma, but only papilloma. It was thought, however, that there was no question of the diagnosis as it was proved twice at the first hospital. The lesion was early but a definite malignant process.

**Chairman:** Primary carcinoma of the vagina is relatively rare and it is fortunate that this one was

detected while still an early lesion. We have no further information from doctor A but there appears to have been some delay in referring the patient to the hospital. There was also some hospital delay in establishing the diagnosis.

**Case III.** R. D. White. Age: 40 years. Married. Para 3. Patient first seen in hospital gyn. clinic in February of 1950 because of diabetic vulvitis. Biopsy of the cervix at this time was very suspicious of malignancy. In March, biopsy said to show "question of intraepithelial carcinoma of the cervix." In May, two biopsies were reported as chronic cervicitis. Patient requested to return in three months but failed to keep the appointment. In September, 1951, patient had elective Caesarian because of diabetes—a low cervical section was done and the right uterine artery was lacerated and thereafter a sub-total abdominal hysterectomy was performed. (Ob. history notes cervix as "markedly eroded—consider biopsy," but this apparently was not done.) In 1952, patient was followed in diabetic clinic. She did not return to gyn. clinic until July 1953, at which time she was complaining of urinary tract symptoms. July 9th, biopsy showed "probable epidermoid carcinoma, cervix." Examination revealed a mass in the left paracervical region which was thought to be an enlarged pelvic lymph node. Patient hospitalized for biopsy of this mass and conization.

*Diagnosis:* Epidermoid carcinoma, cervical stump, I. C. III.

*Treatment:* Deep x-ray therapy. Radium.

**Chairman:** This is one of our cases and I have reviewed the slides. My feeling is that the sections showed definite intraepithelial carcinoma in March of 1950; normal cervix in May 1950; invasive cancer in July 1953.

**Committee member:** This has been an extremely interesting case. It is one of the rather rare cases where there is no gross lesion on the cervix, but microscopically invasive cancer. This cervix looked normal even at the time the mass in the left paracervical region showed definite invasive cancer. I feel that there was certainly delay on the part of the hospital and that probably even in 1950 the patient was followed too long without conization. Lack of co-operation on the part of the patient was a factor but not an excuse. She was subsequently followed in other clinics in the hospital but apparently not referred back to gynecology for further investigation.

**Chairman:** I do not feel that there can be criticism of the obstetrical department in doing a sub-total hysterectomy as the emergency procedure at the time of the Caesarian section.

**Visiting surgeon:** There is no criticism of the surgery but with the patient's history of questionable

intraepithelial carcinoma, it seems that a later biopsy of the cervix was indicated.

*Committee member:* It undoubtedly should have been done but for some reason was overlooked.

*Committee member:* This case presented many complications but in the final analysis it appears to be a case of intraepithelial carcinoma which "got away." I would like to point out that in 1950 cases of possible intraepithelial carcinoma were not followed as they are today. At the present time in this hospital careful records and follow-ups are maintained on all of these patients.

**Case IV. F. J. White.** Age: 29 years. Married. Para 7. Menses said to be normal to June 1953. Normal period June 1st. No period in July and August—consulted doctor A—was examined and found to be pregnant. Beginning in the third month of pregnancy and continuing, a malodorous vaginal discharge with occasional slight bleeding. Patient was told by doctor A that she had a "torn place." In October or November she received penicillin injections for the discharge. December 27th, an episode of moderate vaginal bleeding—consulted doctor A who advised bed rest. Bleeding recurred more profusely on December 31st and patient was admitted to the hospital. Examination under anaesthesia on January 4th, revealed a "growth on the mouth of the womb." Patient was transferred to second hospital for therapy. Biopsy showed epidermoid carcinoma. Caesarian section and removal of tubes, January 11th, 1954.

*Diagnosis:* Epidermoid carcinoma, cervix, I. C. II, late.

*Treatment:* Radium and deep x-ray therapy.

*Chairman:* We regret that doctor A is unable to attend the meeting today and we have no further information to add to the history as given in the abstract. This case is similar to several others seen during the Committee's study where there was a rather far-advanced malignancy which was not detected until late in the pregnancy. Physicians too often have in mind only the possibility of abortion and thus the actual cause of irregular bleeding is not determined. In some cases a pelvic examination has not been done.

*Visiting surgeon:* In this case the attending physician made repeated pelvic examinations throughout the pregnancy but did not biopsy the cervix.

*Committee member:* By the time the patient was hospitalized for treatment she had a very bad looking cervix—almost a stage 3. Before a definite decision had been reached as to how best to treat this case, the patient's membranes ruptured spontaneously and therefore the Caesarian was done prior to radium

treatment. The removal of the tubes was advised at the time of operation in order to eliminate the possibility of salpingitis as a complication.

There was discussion of the rather wide-spread, but erroneous, impression that biopsying a cervix will upset a pregnancy. A study made at the Hopkins Hospital was quoted. In this series of 260 cases where the cervix was biopsied during pregnancy there was only one abortion and one serious hemorrhage thought to be attributable to biopsy.

**Case V. I. H. White.** Age: 46 years. Married. Para 1. Menses normal to September, 1952. Following period in September, moderate vaginal discharge which continued for two weeks. Regular periods October–March, but slight spotting or moderate bleeding almost daily between periods. March, 1953, moderately profuse bleeding for one week—consulted doctor A—was not examined because of the bleeding—given an injection and oral medication to check the bleeding and asked to return when bleeding stopped. The bleeding ceased entirely for two weeks in April. The patient thought her symptoms were due to the menopause and did not return to the doctor. May and June, bleeding almost daily. July 5th, "hemorrhage." The patient was taken to the hospital and doctor A called in consultation. Following a diagnostic D. & C. and biopsy the patient was sent to second hospital for treatment.

*Diagnosis:* Epidermoid carcinoma, cervix, transitional cell type, I. C. III.

*Treatment:* Deep x-ray therapy. Radium.

*Chairman:* This case is similar to many which have been presented at these meetings. The patient is not examined because of bleeding, given medication to check the bleeding, and requested to return for examination when the bleeding stops. For varying reasons the patient does not return until after considerable time has elapsed and the disease is rather far-advanced before the diagnosis is made. Had this patient been examined when she first sought medical advice she might have come to treatment much earlier.

*Committee member:* We have discussed this matter many times but apparently we cannot emphasize too strongly that bleeding is not a contra-indication to examination. Examination at this time may often be a help in establishing a diagnosis.

**Case VI. L. C. White.** Age: 38 years. Married. Para 2. Patient came to hospital clinic December 9, 1953, because of urinary difficulty—frequency, urgency and pain. Periods said to be normal, no irregular bleeding. Routine Papanicolaou smear reported as class 5. Biopsy done on January 5th re-

vealed intraepithelial carcinoma of the cervix. The patient was hospitalized January 10th for D. & C. and sharp conization. Pathological report: Intraepithelial carcinoma, cervix, with one small area of invasion of submucosa. On January 19th, the patient had a panhysterectomy. The pathology showed intraepithelial carcinoma of the cervix.

This case was presented as of interest because of the detection of the early carcinoma in the absence of definite symptoms.

#### Statistics

Cases to June 1, 1954.....	667
<i>Classification:</i>	
Patient Delay.....	303
Physician Delay.....	56
Patient and Physician Delay.....	36
Institutional Delay.....	20
Physician and Institutional Delay.....	3
Patient and Institutional Delay.....	13
Patient, Physician and Institutional Delay.....	2
No Delay.....	214
Asymptomatic Detected Cases.....	20

#### COMMITTEE ON PUBLIC MEDICAL EDUCATION

H. HANFORD HOPKINS, M.D.\*

In the Fall of 1953, Dr. Amos Koontz, then Chairman of the Committee on Public Medical Education of the Baltimore City Medical Society, conceived the idea of making available to the Public, information on Medical subjects of popular appeal through the medium of a group of speakers who might volunteer from among the members of the Baltimore City Medical Society.

With the help of the A. M. A. and other agencies, a list of topics was prepared, and on November 30, 1953, mailed to the lay organizations of Baltimore and its environs for which addresses were available.

\* Chairman, Committee on Public Medical Education.

At the same time a panel of volunteer speakers on the various subjects was compiled.

Since the beginning of the program, requests for forty-five talks have been answered, and the engagements fulfilled by thirty-four different doctors. The medical subjects selected by the Public have been quite varied except that recently as might be expected there has been a rash of requests for talks on cancer of the lung.

We have no means of knowing whether or not all expositions have been well received, but feel very much encouraged in our effort by the complete absence of adverse criticism, and very naturally by the following letter, which among other letters of similar nature, I think will be of some interest to all Maryland doctors who read it:

#### BALTIMORE FEDERATION OF LABOR

Affiliated with the American Federation of Labor  
1131 Harford Avenue  
Baltimore 2, Maryland  
Phone Peabody 2-6021

July 22, 1954

"Dr. H. Hanford Hopkins, Chairman  
Committee on Public Medical Education  
Baltimore City Medical Society  
1211 Cathedral Street  
Baltimore 1, Maryland

My dear Dr. Hopkins:

Last evening, Dr. Carleton C. Douglass addressed our organization on "Cancer of the Lung," and I might add that the delegates to our meeting were greatly impressed with Dr. Douglass's remarks and the manner in which he delivered his very informative address.

On behalf of the officers and members of this Federation, I want to take this opportunity to thank you for your part in arranging for our speaker.

If we can ever be of any assistance to you and your organization, please do not hesitate to call upon us.

Sincerely yours,  
(Signed) Francis S. Filbey  
President

July 24, 1954

#### SENATE VOTES MORE VA DENTAL CARE FUNDS

The AMA Washington Letter, No. 72

Indorsing action of its Appropriations Committee, the Senate has approved \$10 million more than the House allowed for Veterans Administration private fee payments to dentists. The committee explained that it took the action because the bill as passed by the House sharply reduced dental care funds, while at the same time it lifted restrictions on dental care. The committee decided on increasing the funds rather than restoring the restrictions.

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## ARTICLES OF INTEREST

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### ON LICENSING LABORATORY WORKERS\*

AMOS R. KOONTZ, M.D.

There is a movement on foot for setting up a State Board in Maryland for licensing medical laboratory workers. Indeed a bill for the enactment of the proposed law is being prepared. The advocates of the law profess the belief that such a law would improve the quality of medical laboratory work in the State. I am not convinced of this and do not see the necessity for the establishment of such a board.

I believe that all medical laboratory workers should work under the supervision of physicians. This practice has worked out very well in the past and I believe should be continued. If medical laboratory workers were licensed, they would be free to carry on their laboratory work without medical guidance, which is undesirable.

As a matter of fact, there is now very little need for licensing physicians, except those who come from

foreign countries. Through the efforts of the American Medical Association all of the old class B and C medical schools have been eliminated. There are now no poor medical schools in the United States. It is the general advance in medical education which has improved medical practice and medical care in this country and not the system of licensing physicians.

The same principles hold with regard to laboratory workers. As medicine improves, they will improve, and if they are required to work under the direction of physicians, there will be no necessity for licensing them.

Should laboratory workers be licensed, they would be withdrawn more or less from medical supervision, and would be enabled to form a guild of their own. This is not desirable. Nurses are licensed and have their own associations, which is desirable in one way but undesirable in others. While the work of nurses has an inseparable relationship to the medical profession, nursing education is not controlled by the medical profession. Nurses training has now become so complicated with lectures and laboratory work that there is very little time for them to spend on patients. Most physicians consider this very undesirable and yet it is beyond their control. We do not want the medical laboratory workers to get into the same situation.

### AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The following candidates from Maryland were certified by the American Board of Obstetrics and Gynecology on May 17, 1954:

Fitzpatrick, Vincent D., Jr., 1120 St. Paul Street, Baltimore, Maryland  
Haught, John S., 3303 Perry Street, Mt. Rainier, Maryland  
McCune, Wallace H., 8208 Fenton Street, Silver Spring, Maryland  
Moody, Louis H., Jr., 918 Ellsworth Drive, Silver Spring, Maryland  
Reist, Vorris M., U. S. Naval Hospital, Bainbridge, Maryland  
Russell, Thomas E., Jr., 3901 North Charles Street, Baltimore, Maryland  
Scher, Ernest, 1701 Eutaw Place, Baltimore, Maryland  
Warren, John F., 6805 Baltimore Blvd., College Park, Maryland

# Component Medical Societies

## ALLEGANY-GARRETT COUNTY MEDICAL SOCIETY

LESLIE E. DAUGHERTY, M.D.

*Journal Representative*

Lt. Col. J. Norman Reeves will report for overseas duty after spending a few days furlough at his home in Westernport, Maryland.

Dr. Wylie Faw has been elected to The Maryland State Board of Medical Examiners.

Dr. Hilda Jane Walters, Frostburg, Maryland, was injured in a highway collision.

Dr. Benedict Skitarelic, Director of Laboratories, at the Memorial Hospital, in Cumberland, has promoted a Sports Car Race.

Dr. Raymond W. Reeves of Westernport, the twin brother of Lt. Col. J. N. Reeves, will report for active duty with the Air Force.

Dr. Ralph Ballin addressed the Maryland State Nurses Association, District 1, on May 26, 1954. Dr. Ballin spoke on "Psychosomatic Aspects of Heart Disease."

Dr. Ralph Roth, of Cumberland, Maryland, plans to study at Jefferson Hospital, Philadelphia, Pennsylvania.

Dr. Leonard S. Cooper, of Cumberland, plans to leave local medical duties in order to specialize in surgery at Sayre, Pennsylvania.

Dr. Cooper expects to return to Cumberland to engage in surgery.

Dr. Harold W. Eliason has been appointed Physician to the Cumberland City Health Department, effective July 1, 1954.

Dr. Eliason has lived in Cumberland since 1928. He graduated from the University of Maryland in 1927, after attending St. Johns College, Annapolis and the West Virginia University. Dr. Eliason's practice is limited in Pediatrics and he holds the position of Chief of Pediatrics at Cumberland and Allegany County's Memorial Hospital. He is a native of Rowlesburg, West Virginia.

Dr. W. E. Gattens, of Frostburg, Maryland, was elected president of the medical staff of Miners

Hospital, in Frostburg, Maryland, at a recent dinner meeting.

Other officers named included Dr. H. C. Diehl, vice president; Dr. Martin Rothstein, secretary, and Dr. Hilda J. Walters, Dr. W. O. McLane and Dr. Harry Teter, executive committee.

Dr. Gattens succeeds Dr. Walters as president.

Dr. W. Royce Hodges explains use of "Rockette" for babies.

## BALTIMORE CITY MEDICAL SOCIETY

### SECTION OF GENERAL PRACTICE

KENNETH KRULEVITZ, M.D., *Secretary*

The newly formed Section of General Practice met at the Medical Chirurgical Building, June 10, 1954. This was the first official meeting of the organization. A paper by Dr. Paul Carliner, Chairman of the Baltimore City Emergency Medical Call Program, was read. Following this paper members of the Section held a discussion of the problems involved in handling the large number of emergency calls. A committee of the general practitioners of the Section was formed to participate in further studies with Dr. Carliner's committee. Members of this committee are: Dr. Charles Kerr, Dr. Louis Klimes, Dr. Samuel Rubin, and Dr. Marion Freedman.

The following committees of the General Practice Section are to be formed: Programs Committee, Constitution Committee, Membership Committee, and Public Relations Committee.

The Section intends to meet on the third Thursday of each month at 9:30 p.m. at the Medical Chirurgical Building. This day and time were selected as being most suitable after a questionnaire was sent to the general practitioners of Baltimore City.

The first meeting will be held Thursday, October 21, 1954, at 9:30 p.m. Dr. Joseph Blum, Chairman of the Program Committee, is formulating plans for the first meeting.

Dr. Charles Kerr was appointed Section Representative for the Committee on Scientific Arrangements.

Officers for the 1954-55 term were elected as follows: Dr. Louis Maser, President; Dr. Walter Anderson, Vice President; Dr. Kenneth Krulevitz, Secretary; Dr. Marion Freedman, Treasurer.

It is hoped that all general practitioners will become interested and active members of this Section.

### SECTION ON INTERNAL MEDICINE

#### INTERNAL MEDICINE AND BLUE SHIELD:

##### *I. Fact Finding Committee's Report\**

CONRAD ACTON, M.D., *Chairman*

This Committee was instructed to seek out *facts* concerning medical, as distinguished from surgical, benefits under various Blue Shield, or prepayment medical benefit insurance plans, and report to the Section at this date. The Report to be a basis for any action the Section might decide to take. Relevant facts were sought by:

- (a) Discussion with other physicians.
- (b) Review of pertinent literature.
- (c) Analysis of "Voluntary prepayment Medical Plans"—1953, from A.M.A.
- (d) Conference with Maryland Medical Plan, Inc., representatives:

Mr. R. H. Dabney and Dr. Walter Graham. The following facts as found are herewith submitted.

1. There is a generally recognized—within the medical profession—inequity between surgical and medical benefits under Blue Shield Plans. Manifestations of concern range from "Medical Economics" facile, sort of soap-opera dramatics editorial on page 97 of the July 1953 handout, to the deliberations of the Board of Regents of the American College of Physicians. Their sober and restrained opinion is reported on page 415, (3), in the August 1953 "Annals of Internal Medicine." On motion of Walter Martin, then A.M.A. President-elect, it was agreed that "This ought to go to the Section on Internal Medicine of the A.M.A., to be considered by them and then referred to the proper body of the A.M.A., as to what shall be done . . . ."

2. There are two major barriers to effective understanding between Physicians and Insurance Men.

\* Presented to Section on Internal Medicine, Baltimore City Medical Society, 29 September 1953.

(a) Actuarial terminology, concepts, and philosophy underlie Blue Shield Plans, not medical. These plans are "medical" in name only. For instance, "medical" benefits are paid to surgeons, or other physicians, when they do not operate on a patient.

(b) The concept of insurability. Not everything is insurable. Insurability requires that the item insured against shall be of uncertain or unique occurrence—that the item's occurrence shall be predictable by the laws of chance and probability, if not already on established tables of past experience, like appendicitis, or fractured femurs, in terms of frequency per unit group per time term. On the other hand, an event that is certain to occur is not a risk, and is not insurable. All insurance carriers seem to believe that if a "medical examination," or "diagnosis" however phrased, were included in the various Tables of Benefits, or payments, such a Benefit would be universally indulged in, as in the British experience. The benefit then would have to be added to the subscription rate from the beginning as a "cost" and make the rates unconscionably high.

3. "Benefit" payments of Blue Shield Plans can be compared on a nationwide scale in the booklet "Voluntary Prepayment Medical Benefit Plans—1953." It is prepared and distributed gratis by the Council on Medical Service, A.M.A. Sixty-five of those listed were analyzed. The following facts stand out:

(a) All Plans are not "accepted" as approved by the A.M.A. but are listed. Non-acceptance is for non-conformity to one or more A.M.A. policies. The Maryland Medical Plan is not accepted because participating physicians are paid more than non-participating, 25%.

(b) Eleven (11) plans have NO (not any) medical benefits at all.

(c) Twenty-three (23) pay non-surgical benefits *only after* the first two (2) to five (5) days of hospitalization.

(c) *Maximum (NON-SURGICAL) BENEFIT PER DAY*, usually first day, other days less.

11 pay NOTHING	
5 pay \$2.00	1 pays \$6.00
35 pay 3.00	7 pay 10.00
11 pay 4.00	1 pays 12.50
23 pay 5.00	1 pays 15.00 (MARYLAND)
	1 pays 25.00 (NEW JERSEY)

(d) **Maximum (NON-SURGICAL) BENEFIT PER HOSPITALIZATION** varies naturally with the rate after the first day, and allowed benefit period.

11 pay NO non-surgical benefits.

2 permit a \$50.00 *Total* (Kentucky, W. Virginia)  
1 allows \$603.00 (California)

**MARYLAND** permits a total possible of \$109.00

16 range \$50.00 to \$95.00  
9 range 100.00 to 140.00  
7 range 150.00 to 180.00  
5 range 216.00 to 220.00  
4 range 350.00 to 482.00  
2 range 507.52 to 603.00

4. Benefits are also allowed for CONSULTATIONS. Of 65 evaluated:

(a) Forty-three (66%) have *NO* Consultation benefits at all.

(b) Twenty-two (33%) allow \$10.00 each for total of two consultations per consultant, very uniformly. Occasionally a second consultant may be authorized in some.

(c) No Blue Shield Plan distinguishes between consultants or consultations in any way whatever. A consultation is a consultation. No time limits are set: five minutes equals five days. Investigation is the same as therapy. Specialists rate equally whether fully qualified, semi-detached, or grass-roots calibre.

5. Figures from the MARYLAND MEDICAL SERVICE, Inc., show the following resume of payments of a medical and surgical nature: in 1953: (Final figures compiled in 1954.)

	<i># Claims</i>	<i>\$ Paid</i>	<i>Average</i>
Medical (Non-surgical)	3,003	\$154,611.00	\$51.00
Medical Consultation	763	7,620.50	10.00
Surgical	7,279	473,958.00	85.00
Surgical Consultation	277	2,761.50	10.00

6. The Maryland Medical Plan compares favorably with other plans as outlined in the comparative tables.

7. No Blue Shield Plan distinguishes between TYPES of consultation.

8. No Blue Shield Plan recognizes "non-surgical" specialties in any Table of Benefits.

## BALTIMORE COUNTY MEDICAL ASSOCIATION

SAMUEL P. SCALIA, M.D.

*Journal Representative*

The June meeting of the Baltimore County Medical Association was a joint meeting with the Woman's Auxiliary. It was held at the Ames Fellowship Hall in Pikesville.

As usual, the June meeting is devoted by the Auxiliary to the granting of a nursing scholarship. This year, the women were able to grant two scholarships to two County high school graduates. One girl is to go to St. Agnes Hospital and the other to the Church Home and Hospital.

This nursing scholarship project has been a very worthy one for Baltimore County. The Auxiliary has gained national recognition because of its endeavors. The three previous scholarship winners were guests at the meeting. One girl has just graduated from the University Hospital, one is a senior at Woman's Hospital, and the third one is a second year student at Johns Hopkins Hospital. The Woman's Auxiliary is to be commended for a job well done.

A new idea was introduced by Dr. Warthen concerning chest x-ray reports. Formerly all chest x-rays were routinely read for pulmonary tuberculosis and nothing else; from now on, any other significant chest pathology will also be described in the reports. The patient will be notified that the x-ray showed some pathology and that he should contact his family physician. The doctor will receive a full report of the findings and he takes over from there.

Dr. Isadore Tuerk has had to give up his position as Director of the Alcohol Study Clinic in Baltimore County. Dr. Charles Ward is succeeding him. Dr. Ward discussed the functions of the clinic and its value in the county. He made a request for more referrals from the county physicians. The clinic is very well staffed and running quite smoothly. He feels that they can probably handle more patients than there are at present.

Dr. Robert Thomas was introduced to the membership. Dr. Thomas is succeeding Dr. Paul Lemkau as Director of the division of Mental Health in the State Health Department. Dr.

Thomas outlined the Program of Mental Health in the State and especially in Baltimore County. He stressed the importance of the Mental Health clinic as regards treatment and prevention. A new aspect of the clinic was brought out in that these clinics are now being used for training of psychiatrists, clinical psychologists and psychiatric social workers. The Mental Health clinics certainly deserve full support.

Crabs to delight the palate of the most exacting connoisseur of that famous Maryland dish; Crabs to tickle the taste buds of Baltimore County physicians and cold beer to bathe the warm temperaments of medical men on a hot day: This was the order of the day when the Baltimore County Medical Association held its annual crab feast at Duffy's Restaurant on Wednesday, July 28, 1954.

There were steamed crabs and crab cakes, crab imperial and crab soup, and of course cold beer. A good crowd turned out and everyone had an enjoyable afternoon.

The scientific part of the meeting concerned itself with the digestive processes and their relationship to crabs and beer. It was decided that more research is needed before reaching any definite conclusions. Therefore, it was moved to have another crab feast next year as a form of applied research.

The response to a request for articles for a Baltimore County issue of the State Medical Journal has really been overwhelming. As a result, there will probably be two issues of the JOURNAL devoted to our County. We are all anxiously looking forward to seeing our scientific endeavors in print.

The JOURNAL Representative, Samuel P. Scalia, tendered a request for a two year leave of absence while he goes to do his bit with Uncle Sam's Navy. A replacement will be selected in the near future.

### **CAROLINE COUNTY MEDICAL SOCIETY**

ROBERT H. WRIGHT, M.D.

*Journal Representative*

The Caroline County Medical Society met at the Tidewater Inn, Easton, on July 1.

The meeting, at luncheon, was to honor Dr. H. Fletcher Silver, Goldsboro. He was presented an engraved silver tray by the members of the society with best wishes for many more years of activity.

Members absent: Dr. Charles Stonesifer and Dr. Damson George.

### **DORCHESTER COUNTY MEDICAL SOCIETY**

ALFRED R. MARYANOV, M.D.

*Journal Representative*

The members of this society were deeply shocked by the sudden death of Dr. Walter B. Johnson on Friday evening, June 4, 1954. Dr. Johnson died of a coronary embolus while attending a Rotary Outing.

Dr. Johnson was secretary to the Dorchester County Medical Society, as well as Dorchester County Health Officer, since 1948. His untimely death has been deeply felt by the members of this society and his community.

At the present time, and for the next five years, the school children in Dorchester County will be undergoing a survey by dentists from The United States Public Health Service, to determine the value of fluorination of water in preventing dental caries. It has been determined that an optimal amount of fluorine is naturally present in the water supply of this county, and for this reason, Dorchester County has been chosen for the survey.

### **MONTGOMERY COUNTY MEDICAL SOCIETY**

DEWITT E. DeLAWTER, M.D.

*Journal Representative*

Excerpts from the minutes of May 18, 1954, meeting of the Montgomery County Medical Society.

The final meeting of the Montgomery County Medical Society before the summer season was held on May 18, 1954, at the Olney Inn. Dr. M. Sacks was the speaker on the subject "Progress in Blood Coagulation."

**Business:** Although the six member delegation was sent to the Spring meeting of the State Society uninstructed, they were advised that the Montgomery County Society opposed any assessment of the members for a new faculty building so long as a portion of the funds were to be used for the support

and maintenance of a library. Perhaps the assessment would be more readily accepted if someone would explain in the pages of the JOURNAL the need for the continuation of the library and its historical volumes.\*

It was announced that Dr. V. L. Ellicott has resigned as county health officer after more than twenty years of service in that capacity. As yet the county authorities have not announced a successor to Dr. Ellicott.

The Montgomery County Medical Society has volunteered to supply material for one issue of the JOURNAL. Dr. James McCarrick has been appointed to take charge of collecting and organizing the material for that issue.

The tentative schedule for our fall program is as follows:

**September 21, 1954**

Program—Correctable Heart Disease.

Panel Discussion. Director by Dr. Proctor Harvey, Georgetown University Hospital.

Place—Olney Inn.

**October 19, 1954**

Program—“Infectious Hepatitis”

Place—Clinical Center, National Institutes of Health, Bethesda, Maryland.

\* An Editorial explaining this matter will be published in a forthcoming JOURNAL.

November 16, 1954

Program—Dinner Dance.

Place—Woodmont Country Club.

December 21, 1954

Program—Kidney Disease. Speaker, Dr. George Shriner, Georgetown University Hospital.

Place—Olney Inn.

**ST. MARY'S COUNTY MEDICAL ASSOCIATION**

J. R. GUYTHER, M.D.

*Journal Representative*

At the April meeting of the Medical Society, the members present unanimously approved a resolution favoring the principle of free choice of physicians to all employees covered by the Workman's Compensation Law. It was noted that at the present time it is the policy of the State Industrial Accident Commission to have a designated physician care for industrial accident cases. This policy denies the patient free choice except under special circumstances.

St. Mary's County is in the midst of an active fund raising campaign with a goal of \$250,000 to finance the construction of a new wing for the St. Mary's Hospital. The campaign is being conducted by the professional fund raising firm of A. J. Hanney Association and will climax in September. A successful campaign is expected.

**HOUSE COMMITTEE APPROVES NEW “PRESUMPTIVE” BILL**

The AMA Washington Letter, No. 71

Chairman Edith Nourse Rogers of the House Veterans Affairs Committee is pressing for a House vote on a bill (H.R. 8789) which would increase the presumptive period for multiple sclerosis, psychoses and arthritis to three years. Currently arthritis is one year, psychoses and multiple sclerosis two. In the face of adverse reports from the Veterans Administration and the Budget Bureau, the committee on Wednesday voted out the bill. Mrs. Rogers will seek a special rule in order to get it on the House floor as soon as possible. In opposing the bill, VA Administrator Higley warned that its passage might “be urged as a precedent for extending the presumptive period for many other chronic diseases.” He reminded the committee also that veterans affected would become eligible for outpatient treatment. The American Medical Association is opposed to the bill, contending that the theory of presumption of service-connection by fiat is *medically and scientifically unsound*.

# Library

"Books shall be thy companions; bookcases and shelves, thy pleasure-nooks and gardens." *ibn Tibbon*

## DIABETES

LOUIS KRAUSE, M.D.\*

In the Papyrus Ebers of 1500 B.C., there is a prescription recommended for the purpose "to drive away the passing of too much urine." It goes on to talk about the thirst associated with increased output. This, plus the other description in the text, certainly suggests the presence of the condition that we recognize as Diabetes at this time. Then a little more than a millennium later, Aretaeus, the Cappadocian, gave a very good description of the symptoms of Diabetes, particularly stressing the increased intake of water and output of urine. The name itself in the Greek comes from this very observation: from dia betes—to go through like a siphon.

Another millennium later, we have a correct, but complicated description by Paracelsus in his *Tractatus III, De Diabetica*. In 1679, Thomas Willis was the first to separate the Diabetes Mellitus or sugar diabetes from Diabetes Insipidus or water diabetes. He noted that the urine in Diabetes Mellitus tasted sweet and in his words, "sweet as imbued with sugar or honey." In 1848, the Xanthoma of the Diabetes was described by Thomas Sydenham. The deep, uninterrupted regular breathing of diabetic coma was described by Adolph Kussmaul. In 1890, Oskar Minkowski and Von Mehring related the pancreas to Diabetes.

In this country in 1900 at Johns Hopkins, Opie described hyaline degeneration in the pancreas. Then in 1923, the era of Insulin began, introduced by Frederick Banting, Charles Best and MacLeod of Canada. From then on, Diabetes and its control and complications have been greatly illuminated and in the following list of books the story of "sugar diabetes" is still being unfolded.

## DIABETES

Aretaeus, the Cappadocian. Extant works. London, Sydenham society, 1856.

\* Chairman, Library Committee.

- Paracelsus. *Opera omnia*. Genevae, I. Antonij & Samuelis De Tournes, 1658.
- Willis, T. *Pharmaceutice rationalis*. London, R. Clavell, 1679.
- Sydenham, T. *Opera universa*. Lugduni, Johannem a Kerchem, 1726.
- Cullen, W. *First lines on the practice of physic*. Edinburgh, Wm. Creech, 1777.
- Home, F. *Clinical experiments, histories & dissections*. Edinburgh, Wm. Creech, 1780.
- Rollo, J. *Cases of the diabetes mellitus; with the results of the trials of certain acids, and other substances, in the cure of the lues venerea*. 2d ed., London, C. Dilly, 1798.
- Gregory, G. *Elements of the theory and practice of physic*. 1st ed., London, Burgess & Hill, 1823.
- Prout, W. *On the nature & treatment of stomach & renal diseases*. 4th ed., London, J. Churchill, 1843.
- Camplin, J. M. *On diabetes, and its successful treatment; from the 2d Lond. ed.* New York, S. S. & W. Wood, 1861.
- Harley, G. *Diabetes*. London, Walton & Maberly, 1866.
- Donkin, A. S. *On the relation between diabetes & food*. New York, Putnam, 1875.
- Bernard, C. *Lecons sur le diabète et la glycogenèse animale*. Paris, Baillière, 1877.
- Cantani, A. *Der diabetes mellitus*. Berlin, Denicke, 1880.
- Tyson, J. *Treatise on Bright's disease & diabetes*. Philadelphia, Lindsay & Blakiston, 1881.
- Hirsch, A. *Handbook of geographical and historical pathology*. London, New Sydenham society, 1883-86.
- Schnée, E. *Diabetes, its cause and permanent cure*. London, H. K. Lewis, 1889.
- Düring, A. *Ursache und Heilung des Diabetes Mellitus. (Zucker Krankheit)*. Hannover, Schmorl & von Seefeld Nachf, 1892.
- Minkowski, O. *Untersuchungen über den Diabetes Mellitus nach Exstirpation des Pankreas*. Leipzig, F. C. W. Vogel, 1893.
- Seegen, J. *Der Diabetes Mellitus auf Grundlage zahlreicher Beobachtungen dargestellt*. 3. aufl. Berlin, A. Hirschwald, 1893.
- Pavy, F. W. *The physiology of the carbohydrates, their application as food and relation to diabetes*. London, J. & A. Churchill, 1894.

- Noorden, K. H. von. Die Zuckerkrankheit und ihre Behandlung. Berlin, A. Hirschwald, 1895.
- Lenne, A. Wesen, Ursache und Behandlung der Zuckerkrankheit (Diabetes Mellitus). Berlin, S. Karger, 1898.
- Williamson, R. T. Diabetes mellitus and its treatment. Edinburgh, Y. J. Pentland, 1898.
- Opie, E. L. Disease of the pancreas, its cause and nature. Philadelphia, Lippincott, 1903.
- Naunyn, B. Der Diabetes Melitus. 2. umgearb. Aufl. Wien, Alfred Hölder, 1906.
- Pavy, F. W. On carbohydrate metabolism. London, J. & A. Churchill, 1906.
- Lusk, G. Metabolism in diabetes. (The Harvey Lectures) Philadelphia, Lippincott, 1908-09.
- Lepine, R. Le diabète sucre. Paris, Baillière, 1909.
- Noorden, K. B. von. New aspects of diabetes; pathology and treatment. New York, E. B. Treat, 1912.
- Allen, F. M. Studies concerning glycosuria and diabetes. Cambridge, Harvard Univ. Press, 1913.
- Cammidge, P. J. Glycosuria and allied conditions. New York, Longmans, Green, 1913.
- Hill, L. W. The starvation treatment of diabetes, with a series of graduated diets used at the Massachusetts general hospital. Boston, W. M. Leonard, 1915.
- Allen, F. M., Stillman, E., and Fitz, R. Total dietary regulation in the treatment of diabetes. New York,
- Rockefeller Institute for Medical Research, 1919. (Monograph no. 11)
- Banting, F. G. The internal secretion of the pancreas. Toronto, The University library, 1922. (Reprint from "Jour. of Lab. and Clin. Medicine," 1922.)
- Joslin, E. C. Diabetic metabolism. Washington, Carnegie Institution of Washington, 1923. Publication no. 323.
- MacLeod, J. J. R., and Banting, F. G. The antidiabetic functions of the pancreas and the successful isolation of the antidiabetic hormone—insulin. St. Louis, Mosby, 1923.
- MacLeod, J. J. R. Carbohydrate metabolism and insulin. London, Longmans, 1926.
- McKittrick, L. S., and Root, H. F. Diabetic surgery. Philadelphia, Lea & Febiger, 1928.
- White, P. Diabetes in childhood and adolescence. Philadelphia, Lea & Febiger, 1932.
- Wilder, R. M. Clinical diabetes mellitus and hyperinsulinism. Philadelphia and London, Saunders, 1940.
- Duncan, G. G. Diabetes mellitus, principles and treatment. Philadelphia, Saunders, 1951.
- Duncan, G. G. Diseases of metabolism. 3d ed. Philadelphia, Saunders, 1952.
- Joslin, E. P. The treatment of diabetes mellitus. 9th ed. Philadelphia, Lea & Febiger, 1952.
- Warren, S. The pathology of diabetes mellitus. 3d ed., Philadelphia, Lea & Febiger, 1952.

#### BLUE SHIELD, BLUE CROSS OPPOSE TAX TREATMENT OF HEALTH PLANS

The AMA Washington Letter, No. 72

Senate Finance Committee has received strong protests from Blue Cross and Blue Shield Commissions and Associated Hospital Services of Wisconsin over two sections in the tax revision bill which they say are a threat to further growth of voluntary health insurance.

The committee's attention was called to the fact that under the bill the present tax-exempt status of all health insurance benefits would be ended. Instead, the recipient would be required to regard the payments as taxable income, unless the plan making the payment "qualifies" with the Internal Revenue Bureau. It was pointed out that the qualifying requirement probably would not be too great a burden on the larger employers "with skilled and experienced legal and personnel departments," but that the smaller employers' plans would find it practically impossible to present to the Internal Revenue the analyses and other data required to qualify the plan and thereby to relieve subscribers of tax liability for benefits received.

Commented the Blue Cross Commission: "The mere suggestion that these informal simple arrangements (for health plans) involve questions of tax liability is bound to be a serious deterrent to the making of such arrangements."

The Senate committee is now working over the House-passed measure in executive session and already has given tentative approval to liberalizing income tax deductions for medical expenses. (This particular proposal has been backed by the American Medical Association.)

# Health Departments

## STATE OF MARYLAND DEPARTMENT OF HEALTH MONTHLY COMMUNICABLE DISEASE REPORT

Case Reports Received during 4-week Period, July 30-August 26, 1954

	CHICKENPOX	DIPHTHERIA	GERMAN MEASLES	HEPATITIS, INFECT.	MEASLES	MENINGITIS, MENINGOCOCCUS	MUMPS	POLIOMYELITIS, PARALYTIC	POLIOMYELITIS, NON-PARALYTIC	ROCKY MT. SPOTTED FEVER	STREP. SORE THROAT INCL. SCARLET FEVER	TYROID FEVER	UNDULANT FEVER	WHOOPING COUGH	TUBERCULOSIS, RESPIRATORY	SYPHILIS, PRIMARY AND SECONDARY	GONORHEA	OTHER DISEASES	DEATHS
Total, 4 weeks																			
Local areas																			
Baltimore County	2	—	1	—	1	—	3	5	3	—	—	1	—	—	2	17	—	5	—
Anne Arundel	1	—	—	—	2	—	1	1	—	—	—	—	—	—	—	4	1	5	—
Howard	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—
Harford	1	—	1	—	1	—	2	1	—	—	—	—	—	—	—	6	—	e-1	—
Carroll	—	—	—	1	1	—	—	—	—	—	2	—	—	3	1	—	—	—	1
Frederick	—	—	2	8	3	—	—	—	—	—	—	1	—	—	4	3	5	—	—
Washington	—	—	—	1	2	—	—	—	—	—	—	—	—	2	4	—	9	—	—
Allegany	1	—	—	1	5	—	—	—	—	—	2	—	—	—	5	—	—	—	—
Garrett	—	—	—	3	1	—	—	—	—	—	—	—	—	—	1	—	—	—	—
Montgomery	2	—	2	4	7	—	8	2	1	—	—	—	—	7	3	—	4	c-1	1
Prince George's	4	—	—	1	6	—	5	1	—	—	1	—	—	8	11	—	2	e-1	—
Calvert	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Charles	—	—	—	1	2	—	—	—	—	—	—	—	—	—	2	—	—	—	—
Saint Mary's	3	—	—	1	2	—	—	—	—	—	—	—	—	13	—	—	—	—	2
Cecil	—	—	—	—	—	—	—	2	2	—	—	—	—	—	3	—	1	—	2
Kent	—	—	—	—	4	—	3	—	—	—	—	—	—	2	—	—	—	—	—
Queen Anne's	—	—	—	—	—	—	—	—	—	—	—	—	—	2	1	—	1	—	—
Caroline	—	—	—	—	—	—	—	—	—	—	—	—	—	2	—	—	—	—	—
Talbot	—	—	—	—	—	—	—	—	1	—	—	—	—	—	1	—	5	—	—
Dorchester	—	—	—	—	—	—	—	—	1	—	2	—	—	—	1	—	9	—	2
Wicomico	—	—	1	—	—	—	4	—	2	—	—	—	—	4	3	19	—	—	2
Worcester	—	—	—	—	3	—	—	—	—	—	—	—	—	3	2	—	1	—	—
Somerset	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	1	—	—	—
Total Counties	14	0	7	22	40	0	26	14	8	2	6	1	0	42	73	8	67	8	
Baltimore City	11	0	5	2	11	0	23	7	8	1	21	0	0	49	93	5	429	11	
State																			
July 30-Aug. 26, 1954	25	0	12	24	51	0	49	21	16	3	27	1	0	91	166	13	496	19	
Same period 1953	19	1	13	28	32	0	132	74	65	7	10	6	1	42	165	4	635	23	
5-year median	26	1	12	—	39	2	65	62	—	15	14	4	3	76	211	26	716	25	

### Cumulative totals

State																			
Year 1954 to date	2975	10	283	665	11346	26	2675	36	22	19	1279	12	4	612	1462	116	4741	363	
Same period 1953	2677	9	1415	328	1454	58	2179	125	102	18	2167	19	9	217	1596	95	5219	524	
5-year median	3024	21	936	—	4164	41	1484	98	—	43	858	20	26	382	1869	295	4810	412	

c = congenital syphilis under 1 year of age.

e = encephalitis, infectious.

## BALTIMORE CITY HEALTH DEPARTMENT

### Poliomyelitis and Gamma Globulin—1954

In a recent *Saturday Letter To The Mayor* the Commissioner of Health of Baltimore reported on the current City Health Department policy with regard to the use of gamma globulin. The Health Department's position followed the action of the Maryland State Board of Health on this matter. The text of the *Saturday Letter* is as follows:

"The Honorable Arthur B. Price,  
Acting Mayor of Baltimore City  
City Hall  
Baltimore 2, Maryland

Dear Mr. Price:

There is transmitted to you herewith the weekly Morbidity and Mortality Statistical Report of Baltimore for the week ending June 10, 1954.

Because of the general public interest in poliomyelitis at this season and the confusion in the minds of many regarding gamma globulin I believe you will be interested in the letter I sent yesterday to all physicians in Baltimore relative to this matter. The letter is as follows:

'June 10, 1954

Dear Doctor:

Much thought has been given during recent weeks by the State, City and County Health Departments to the puzzle presented by the availability of gamma globulin this summer, and its apparent lack of proven value in relation to preventing or modifying poliomyelitis.

You will remember that in the press dispatches of

May 6 the public was informed of the action taken on this matter by the State Board of Health as follows:

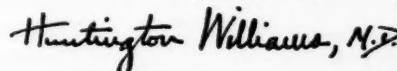
The Maryland State Board of Health at its meeting of April 14, 1954, studied the "Summary Report of the National Advisory Committee for the Evaluation of Gamma Globulin in the Prophylaxis of Poliomyelitis in 1953" as published in the Journal of the American Medical Association of March 27, 1954. It was the considered opinion of the Board that no present evidence existed from the 1953 tests, as set forth in the "Summary Report," that Gamma Globulin is of value in the prevention or modification of poliomyelitis.

Nevertheless, since there is at present some division of opinion on this matter, and since Gamma Globulin will be available in 1954, the Maryland State Department of Health will supply Gamma Globulin to practicing physicians on their request after consultation with the local health officer, if, in the judgment of the physician, he wishes to use it.

Enclosed for your information is the stencilled matter on Gamma Globulin—1954 recently prepared by the Maryland State Department of Health, and an editorial on the Polio-Gamma Globulin situation from the April 29, 1954 issue of the New England Journal of Medicine.

In view of the present situation the Baltimore City Health Department will not encourage the use of gamma globulin in connection with poliomyelitis in 1954.

Very truly yours,



Commissioner of Health"

### MEDICAL REPRESENTATIVES ASSOCIATION

The Medical Representatives Association of Baltimore, Maryland, an association of Medical representatives, as a service to the Medical and Allied professions have compiled, printed and are now distributing to each physician practicing in the Baltimore and Metropolitan area, a directory. This directory lists the names, addresses and phone numbers of medical representatives assigned to the Baltimore area.

Every effort has been made on the part of the association to make this directory as complete as possible so that a physician may contact a representative for information concerning his products. Distribution of the directory will be made in person to each physician, where possible.



# Blue Cross - Blue Shield



## HEALTH SERVICE, INC.—THE NATIONAL BLUE CROSS ORGANIZATION

R. H. DABNEY\*

In an industrial age when large firms have employees scattered across the nation, there is a demand for coverage of all employees under uniform hospitalization benefits at uniform rates. This demand stemmed principally from those organizations whose employees were members of the large national unions, and where the employer contributed to the cost of hospitalization coverage.

To meet this problem and to help local Plans enroll and service large national accounts, Blue Cross Plans in 1949 organized Health Service, Incorporated, a stock insurance company wholly owned by the Blue Cross Association, a non-profit corporation established on authority of the Blue Cross Commission. Blue Cross Plans contributed the funds for the necessary working capital and paid-in surplus of the corporation, much in the same manner as hospitals loaned funds to get the Blue Cross Plans started. By virtue of their contributed capital, the Blue Cross Plans elect ten of the fifteen directors of Health Service, the other five being appointed by the Blue Cross Association.

Here's how Health Service works. A large organization with branches and operations in many different states requests Blue Cross coverage for all of its employees, specifically the *service benefits* which only Blue Cross can provide. Health Service works out a basic contract, with benefits fitted to the company's needs, and develops a uniform rate for the contract based on the rates of each local Blue Cross Plan involved. Health Service handles the enrollment of the group, with assistance locally where necessary, and collects the payroll-deducted subscription rates through one master bill to the company's home office.

Insofar as possible, Health Service "farms out" the coverage to the local Blue Cross Plans in whose areas the employees are located. In Maryland, for

\* R. H. Dabney, Director, Maryland Hospital Service, Inc., Maryland Medical Service, Inc.

example, we would underwrite the coverage to the extent of our regular benefits, and receive from Health Service our regular rates for those benefits. When the basic national contract is broader than our own, we would provide the extra benefits as required, but be fully reimbursed by Health Service. In this way, the subscriber always receives the full benefits under his basic national contract; administratively, the cost is underwritten jointly by Health Service and the local Plan.

Health Service is more flexible than most local Blue Cross Plans, and employers can have a fairly wide choice of benefits to suit their needs. For example, contracts may offer full service benefits for 30 days, 70 days, or even 120 days. Maternity may be provided on a flat indemnity basis, \$80 most frequently, or on a full service basis. Private room allowances may vary, too. With respect to outpatient coverage and exclusions, the contracts follow an established pattern.

To make the Health Service program work requires the cooperation of all Blue Cross Plans, as well as all the member hospitals of each Plan. The subscriber carries a special Health Service membership card, which carries the name of his local Blue Cross Plan, and member hospitals handle the admissions just as if he were a local subscriber. Hospitals here have cooperated with us 100% on these special accounts, and largely because of this, our experience with Health Service groups has been excellent. We now have 30 of these groups enrolled locally, covering some 1,842 contracts and 4,672 subscribers.

There is also a similar national organization for surgical-medical coverage—Medical Indemnity of America—organized by the Blue Shield Plans. There is a joint administrative staff for both organizations, and contracts are handled together when the additional surgical-medical coverage is desired. Because of wide variations in service coverages under local Blue Shield Plans, however, arrangements for local participation cannot be worked out in most areas. Eventually, it is hoped that this can be arranged in a manner similar to Health Service.

# Maryland Academy of General Practice

Executive Secretary—MR. WILLIAM J. WISCOTT, 3722 Greenmount Avenue, Baltimore

## SIXTH ANNUAL SCIENTIFIC ASSEMBLY, LORD BALTIMORE HOTEL, OCTOBER 21, 1954

Another instructive day-long program of post-graduate lectures has been arranged by the Program Committee, Dr. Lauriston L. Keown, Chairman, and Dr. Charles F. O'Donnell, Co-Chairman. The annual banquet will be held in the evening; the principal address will be given by Dr. Edward J. Stieglitz, Physician, Lecturer, and Editor, of Washington, D. C.

Six outstanding clinicians and teachers will address the Academy—coming from Cleveland, New York, Boston, Philadelphia—on problems in medicine, surgery, dermatology, neurology, ophthalmology and pediatrics. They will present timely and practical information on "Advancement in Therapy of Chronic Emphysema," "Changing Trends in Abdominal Surgery," "Dermatology in General Practice," "Parkinson's Disease and Its Treatment," "Some Common Diseases of the Eye," and "Regurgitation in Infants."

All members of the Medical and Chirurgical Faculty, as well as all medical residents and interns in Maryland hospitals, are cordially invited to attend this Sixth Annual Scientific Assembly of the Maryland Academy. There is no registration fee for the Scientific program.

The Committee urges that the physicians bring their wives. An interesting program, including luncheon, is being arranged for them. Tickets for the reception and banquet may be obtained from Mr. Wm. J. Wiscott, 3722 Greenmount Avenue, Baltimore 18, at a charge of \$7.00 per plate for physicians, and \$5.00 for their wives.

### PROGRAM

9:00-10:00 Registration—Caswell Room

Morning Session

*Moderator*—Dr. Nathan E. Needle

10:00 A.M. "Some Common Diseases of the Eye and Their Treatment."

Dr. Roy O. Scholz,

*Instructor Ophthalmology, Johns Hop-*

*kins University Medical School, Baltimore.*

11:00 A.M. "Changing Trends in Abdominal Surgery."

Dr. George Crile, Jr.,  
*Surgeon, Cleveland Clinical Foundation Hospital, Cleveland.*

12:00-1:00 P.M.—Lunch

### Afternoon Session I

*Moderator*—Dr. Norman E. Sartorius, Jr.

1:00 P.M.—*In Memoriam*

Necrology by Dr. Philibert Artigiani.

1:15 P.M.—"Parkinson's Disease and its Management."

Dr. Lewis J. Doshay  
*Associate Attending Neurologist, Neurological Institute, New York.*

2:15 P.M.—"Recent Advancements in the Therapy of Chronic Pulmonary Emphysema."

Dr. Maurice S. Segal, M.D.,  
*Clinical Professor of Medicine, Tufts College, Medical School, Boston.*

3:15 P.M.—Recess

### Afternoon Session II

*Moderator*—R. Van L. Campbell, M.D.

3:30 P.M.—"Dermatology in General Practice."

Dr. Donald M. Pillsbury,  
*Professor of Dermatology and Syphilology, Graduate School of Medicine, University of Pennsylvania, Philadelphia.*

4:30 P.M.—"Regurgitation in Infants."

Dr. John Edmund Bradley,  
*Professor and Head of Department of Pediatrics, Medical School, University of Maryland, Baltimore.*

6:30 P.M.—Reception & Cocktails

7:15 P.M.—Banquet

Dr. Lauriston L. Keown, presiding  
Principal speaker, Edward J. Stieglitz, M.D.

Music

**Note: Members of the Maryland Academy who attend this assembly will receive credit for 6½ hours of formal post-graduate study.**

#### ANNUAL BUSINESS MEETING

The Annual Meeting of the Academy will be held in the Lord Baltimore Hotel promptly at 8:15 P.M., Wednesday, October 20th. Business to be transacted includes reports of the officers and committees, elections of officers and new business. All *members are urged to be present.*

#### NEW MEMBERS

Since our last meeting the following physicians have been elected into *active* membership:

Samuel Allen, 18 Fawcett St. Kensington	Morris J. Baylin 5418 Park Heights Ave. Baltimore 15
William H. F. Warthen Balto. Co. Health Dept. County Office Building Towson 4	Gordon Wm. Kelley 6124 41st Ave. Hyattsville
Abram Goldman 206 S. Gilmore Street Baltimore 23	Huntington Williams Baltimore City Health Dept. Baltimore 3
Louis F. Klimes 2623 E. Monument St. Baltimore 5	Leonard H. Golomebeck 7013 Liberty Road Baltimore 7
John Charles Hyle 7527 Belair Road Baltimore 6	J. Ralph Horky Churchville

Lee Bruner Snow  
9013 Flower Ave.  
Silver Spring

Edward Wilson Ditto,  
III  
217 W. Washington St.  
Hagerstown

John Milton Wyman  
7659 Old Georgetown  
Rd.  
Bethesda

Katherine A. Chapman  
3924 Baltimore St.  
Kensington

#### MEMBERSHIP REQUIREMENTS

The prerequisites for becoming a member of the Academy are simply that the physician must belong to the Medical and Chirurgical Faculty of Maryland, and must devote the greater part of his time to the general practice of medicine. Any doctor who has practiced medicine for 30 years or more, or who has attained the age of 70, is eligible to emeritus membership.

One of the chief aims of the A.A.G.P. is to maintain postgraduate education. Each member of the Academy must during each 3-year period, report 150 hours of medical study to be eligible for re-election to membership. One hundred of the 150 hours can be made up by attendance of national, state and local medical society scientific meetings and at regular hospital staff clinical meetings. The remaining 50 hours must be for attendance at formal study courses such as are offered as post-graduate courses at various medical schools and approved hospitals, or such as the scientific meetings sponsored several times a year by the Maryland Academy of General Practice. Actually, during a 3-year period, a busy doctor who cannot get away for prolonged postgraduate courses, can receive enough credit by full attendance at these one-day scientific assemblies.

#### \$3 MILLION MORE ASKED FOR VA

A. M. A. Washington Letter, No. 77

President Eisenhower has requested Congress to appropriate an additional \$3 million for Veterans Administration's inpatient care program for next fiscal year. It would be added to the regular appropriation which already has passed Congress. The President said the money would be needed because of an increasing patient load, the early opening of new psychiatric hospitals, and the necessity to avoid reducing hospital employment "to a degree which would impair present standards of medical care." The President's request came four days after VA Administrator Higley had suggested \$6 million was needed.

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# Specialties

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## MARYLAND RADIOLOGICAL SOCIETY

RICHARD B. HANCHETT, M.D.

At the Second Annual Meeting of the Maryland Radiological Society, Dr. E. Thrall Campbell was elected President; Dr. Webster H. Brown, Vice President; Dr. Paul W. Roman, Secretary-treasurer; and Dr. Richard B. Hanchett, Councilor for the American College of Radiology of Maryland.

The Second Annual Meeting of the Maryland Radiological Society was held at the Hotel Alexander in Hagerstown, Maryland, on Saturday, May 15, 1954. This meeting was attended by a large number of Maryland radiologists with their wives and guests.

Registration was 10:30 a.m. and following this there was a lengthy business meeting and business luncheon. A report on the "Economics of the Practice of Radiology" was presented by a committee consisting of Dr. Paul Roman as Chairman and Dr. J. Howard Franz and Dr. John DeCarlo as members. This report established in a statistical manner the great increase in the amount of x-ray equipment owned by general practitioners and specialists other than radiologists and also a strong trend toward concentration of diagnostic radiological procedures in hospitals. It was voted to continue the work of this committee and to develop as clearly as possible the present position of the practice of radiology to the general practice of medicine.

Dr. Stanley H. Macht reported a statistical survey of the present status of the mal-practice insurance coverage in Maryland as it effects radiologists. This study developed the very significant fact that there was an extremely low claim rate against well trained radiologists. It was voted to continue this study and to correlate the findings with those available in the American Medical Association and in the American College of Radiology.

Dr. E. Thrall Campbell then presented a resolution concerning the relation of the practice of the medical specialty of Radiology to the corporate practice of Medicine in hospitals and the place of Radiology in the Blue Cross, Blue Shield and other insurance programs. After some discussion, this resolution was unanimously approved.

The scientific portion of the program consisted of companion papers on Progress in Radiology. A paper was given in each Radiation Therapy and Diagnostic Roentgenology. Dr. Robert J. Dickson, radiotherapist at the Johns Hopkins Hospital and formerly radiotherapist at the Hammersmith Hospital in London, England, read a paper on "Recent Trends in Radiotherapy." This was discussed by Dr. Harry A. Miller, attending radiologist at the Sinai Hospital in Baltimore. Dr. Theodore F. Hilbush, chief of diagnostic roentgenology of the National Institute of Health, then read a paper, "Recent Trends in Diagnostic Roentgenology." This paper was discussed by Dr. John DeCarlo, chief radiologist at the Baltimore City Hospital. It is expected that these papers will be published later in the Maryland State Medical Journal.

A reception, cocktails and dinner followed later in the day. The guests of honor were Dr. B. B. Kneisley, president of the Medical and Chirurgical Faculty and Mrs. Kneisley.

Following dinner, the meeting was climaxed with the showing of the color motion picture, the recently declassified "Operation Ivy," the explosion of the hydrogen bomb in the Pacific. Dr. Ralph E. Lapp, well-known nuclear physicist, then gave the principal address of the meeting on "Atomic Defense" and emphasized the immediate need for dispersion of industry and active, vigorous civil defense planning.

A special program for the women was arranged by Mrs. E. Thrall Campbell.

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## Ancillary News

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### NURSING SECTION

M. RUTH MOUBRAY, R.N., *Executive Secretary,  
Maryland State Nurses Association*

#### THE NURSING AIDE PROJECT IN MARYLAND\*

Hospital administrators and nursing service directors throughout the country have often expressed a need for better trained auxiliary personnel as a means of improving patient care. The Nursing Aide Project is a program recently devised to meet this need. Through it, workshops are held for instructors in hospitals and nursing homes to teach them how to conduct a training program for auxiliary personnel in their own institutions.

The Nursing Aide Project was planned and is co-sponsored by the American Hospital Association, the Department of Hospital Nursing of the National League for Nursing, and the United States Public Health Service. The Department of Hospital Nursing of the National League for Nursing has the responsibility of assisting local areas in adapting the project to their particular needs.

In October, 1953 the National League for Nursing held a meeting of representatives from Maryland, Delaware, and the District of Columbia in order to outline the proposed program to them and to ask their interest in participating in the project and in serving as a pilot area. Included in this meeting were representatives of the Maryland-District of Columbia-Delaware Hospital Association, the State Leagues for Nursing, the State Nurses Associations, the State Departments of Health, and the State Boards of Nurse Examiners. The group unanimously agreed that the project was much needed and that Maryland, Delaware, and the District of Columbia would participate in the program, serving as a pilot area.

Mrs. Barbara S. Howell, Chairman of the Steering Committee of the Department of Hospital Nursing, Maryland League for Nursing, was elected Chairman of the Nursing Aide Project in Maryland. She had

spent the past four years as Assistant Director of Nursing Service in a Baltimore hospital and was well aware of the problems in providing nursing care for patients in the area. She also had worked closely with the training program for aides and orderlies in the hospital where she was employed.

After the initial October meeting, the program in Maryland moved along swiftly. Funds to finance the project were obtained from two sources: the Department of Vocational Education, Maryland State Department of Education, which provided funds to pay for training time, and the Maryland-District of Columbia-Delaware Hospital Association, which provided funds for traveling expenses in conducting the program.

It was agreed that three teacher-trainers would be adequate for Maryland, and Mrs. Howell, Chairman of the program, agreed to serve also as teacher-trainer for the area of Baltimore City and the surrounding communities. Miss Rose Marie Bishop was selected for the Eastern Shore, and Mrs. Ora Mae Lewis was selected for Western Maryland. The National League for Nursing, responsible for preparing these teacher-trainers for their jobs, secured Mr. Dwight P. Jacobus to conduct an institute for teacher-trainers in the Maryland, District of Columbia, Delaware area. Mr. Jacobus as Supervisor of Educational Services to Industry, Maryland State Department of Education, is well-known for his ability as an on-the-job training expert.

It was decided that a pilot workshop should be held prior to the institute, and this was done late in December. The participants selected for this workshop were from the various types of institutions, as well as from institutions which were anxious to have a training program. All teacher-trainers from Maryland, the District of Columbia, and Delaware then attended a five-day institute, receiving instruction and practice in the procedure to use in

\* Submitted by the Maryland League for Nursing.

workshops for instructors. The teacher-trainers then returned to their assigned areas to begin the task of holding two-day workshops for instructors of auxiliary personnel in hospitals and nursing homes.

In Maryland the response from hospitals to the program has been most gratifying. Numerous two-day workshops have been held, and in many cases, hospitals have sent additional participants after their original participants had returned and reported the values received. All participants in the workshops have been enthusiastic, and this has undoubtedly contributed to the continued interest of the institutions which they represent. The participation of nursing homes in Maryland has been less favorable than that of hospitals, but the enthusiasm of those who have responded and the use to which they have put the information and material received show the value of such a program to their needs. Currently, Mrs. Howell is devoting much time and effort to arousing interest in the program among nursing homes and hospitals which have not as yet participated. The Maryland State Department of Health has also been asked to assist in stimulating interest among nursing homes in the state.

The two-day workshops in Maryland have been conducted whenever possible with homogeneous groups, that is, hospital instructors together and nursing home instructors together, so that problems of common interest can be discussed. Active

participation of all is very essential, and a common background is helpful in drawing the entire group into the discussions. However, in small Maryland communities where this policy has not been adhered to, no difficulty has developed in the sharing of problems. The size of the group is important also, since the techniques to be learned require individual practice. Therefore, a maximum number of ten participants is recommended.

Follow-up visits to each institution sending a participant to one of the workshops are a vital part of the total program. The purpose of the follow-up is two-fold: first, to see whether the institution has been able to complete a "skill-inventory" of its non-professional personnel; and second, to learn whether it has been able to apply the teaching method as learned and practiced at the workshop. The length of time and number of these follow-up visits varies with the size of the institution and the time required to complete the ground work. In some instances one visit has served, and in others a second visit has been necessary after the classes have actually started.

The Department of Hospital Nursing of the National League for Nursing has worked very closely with our pilot area and has given invaluable assistance in every way. It is hoped that their observations will be of value in launching the project throughout the country.

#### WHO ASSEMBLY VOTES INCREASED BUDGET OVER U. S. PROTESTS

The AMA Washington Letter, No. 72

The 7th World Health Assembly has voted a \$9.5 million budget for World Health Organization programs for 1955. This is an increase of \$1 million over this year but \$800,000 under the recommended figure. Delegates voted approval at Geneva after turning down a U. S. proposal that the budget be held to \$8,607,000. According to a Pan American Sanitary Bureau account of the meeting, Dr. Frederick J. Brady, head of the U. S. delegation, declared the U. S. was strongly opposed to any budget that would bring this country's contribution beyond the \$3 million ceiling set by Congress.

Dr. Brady said that this country does not want to find itself "forced into a position of having to depart from a long tradition of faithfully honoring such obligations." The U. S. contribution to WHO has been running around a third of the total budget.



## PHARMACY SECTION



### CONTROLLING DISPENSING OF DRUGS

L. M. KANTNER, PHAR. D.\*

On April 14, 1954 the following regulation, effective June 15, 1954, governing the labeling of prescriptions for drugs (other than narcotic drugs) that may be dispensed only on prescription was adopted by the State Board of Health.

"For those drugs that may be dispensed only on prescription, unless the prescriber has authorized refilling a definite number of times, the container in which such drug is dispensed shall be labeled with the following or similar wording, in addition to the directions for use": "This prescription cannot be refilled except on the prescriber's authorization to the pharmacist."

In connection with this regulation the following letter was sent to every pharmacy in the State:

"Enclosed is a copy of a regulation adopted by the State Board of Health on April 14, to become effective June 15, 1954.

There are two reasons for adopting this regulation. The first is that when persons obtain prescriptions, to which the regulation applies, they are informed upon delivery, as they should be, that the prescription cannot be refilled until the pharmacist obtains the prescriber's authorization.

The second and primary reason for the regulation is because of reports, from authentic sources, that some pharmacists are disregarding the provisions of both the Federal Durham-Humphrey Act and the State Dangerous Drug Act, as these laws apply to refilling prescriptions for legend drugs.

Prescriptions, for legend drugs, that fail to carry authorization to refill a definite number of times indicate, without question, the prescribers did not intend that the patients be supplied more of the medication than the amount prescribed.

\* Secretary, Maryland Board of Pharmacy.

Notwithstanding the therapeutic benefits being derived from the drugs predominantly used today, there are numerous instances where they have untoward effects, some minor, while others are quite serious.

It can be charged that pharmacists who refill prescriptions for legend drugs without the prescriber's authorization are both counter-prescribing and selling legend drugs over-the-counter.

There can be no question but that the majority of pharmacists recognize their moral and legal responsibilities in dispensing drugs and medicines, and they should be protected against those whose ethics can be questioned in safeguarding the public and the maintenance of professional standards.

What should not be lost sight of is that, under the legislation upon which this regulation is based, the penalty for violation is from \$250.00 to \$500.00."

Further comment as to the reason for this regulation would be superfluous. It cannot be denied that physicians are being annoyed and often irritated because of pharmacists calling them to obtain their authorization to refill a prescription. The physician should realize however the pharmacist has no other alternative. Likewise pharmacists also are annoyed and irritated because frequently they are required to make several calls before they can contact the prescriber.

If a pharmacist illegally refills a prescription, and that is the charge, if he ignores legal requirements and a patient suffers damage from use of the prescription, the pharmacist is not only subject to prosecution but to a damage suit as well. As has been pointed out in these columns previously, physicians can save themselves annoyance from pharmacists' telephone calls relative to refilling a prescription, if they would indicate on their prescription to refill a definite number of times or denote not to refill.

A number of physicians are making this a practice and find it most satisfactory.



# Woman's Auxiliary Medical and Chirurgical Faculty



MRS. JOHN G. BALL, *Auxiliary Editor*

## SEMIANNUAL MEETING PROGRAM

HAGERSTOWN, MARYLAND

HOTEL ALEXANDER, CHALET ROOM

THURSDAY, SEPTEMBER 30, 1954

10:00 a.m.	Registration
10:30 a.m.-12:00 noon	General Meeting <i>Speaker:</i> Mr. John M. Martin, Secretary, Committee on Legislation, A. M. A.
12:30 p.m.- 2:00 p.m.	Luncheon with the doctors. Tours: (Meet in the Maryland Room) Washington County Museum of Fine Arts and Hager House "Antiquing"
After 2:00 p.m.	Brandt Furniture Company Moeller Organ Factory Pangborn Corporation Bridge or Canasta, Maryland Room, Hotel Alexander
4:30 p.m.- 6:00 p.m.	Reception and Cocktail Party, Main Ballroom.

*See your husband's program for further information and reservations.*

## REPORT OF NATIONAL CONVENTION OF THE WOMAN'S AUXILIARY TO THE AMERICAN MEDICAL ASSOCIATION, SAN FRANCISCO, CALIFORNIA, JUNE 21-25, 1954

MRS. ALBERT E. GOLDSTEIN,  
PRESIDENTIAL DELEGATE

The Convention schedule began Monday, June 21, 1954 at 9 a.m. with Round Table Discussions on Legislation, Program, Mental Health, Nurse Recruitment, "Today's Health" and Public Relations. The National Chairmen of these committees conducted Round Table Discussions and had speakers to talk on the progress of their work.

Mrs. Edgar Quayle, Chairman of Legislation, introduced Mr. Joseph Stetler from that department of the A. M. A. He discussed subjects that had been of interest throughout the year, among them, The Bricker Amendment, The Veterans

Medical Care Program, Medical Health Insurance and the Federal Social Security Taxation Program for Doctors. Our state had given support to the A. M. A. on all of these debatable questions. The change of administration has not solved the problems of federal expansion into all phases of business, including medicine. We must continue to learn the facts and be able to discuss such bills intelligently. The dangers in many "give-away" bills are not apparent and merit thoughtful consideration.

Dr. Leo Bartemeier, Chairman of the A. M. A. Health Committee, said doctors' wives throughout the nation are going to be asked to translate a truism into practical action. They will try to attack mental health problems at their obvious starting point—with very young children.

Mrs. Richard Stover conducted "Today's Health" Program. Cash awards were made to Utah, Kansas and Arizona for securing the most subscriptions to "Today's Health." A total of

38,189 subscriptions to this magazine was reported for the year. This figure represents an increase of 5,683 over last year. An increase in circulation would increase the advertising potential and cut the magazine overhead. "Today's Health" Chairmen watch for renewal time of your subscribers, canvass doctors and dentists in your county, and suggest gift subscriptions for new mothers. The year 1953 was the best in 25 years of "Today's Health" publication.

Mrs. Harold Johnson conducted the Nurse Recruitment Program and gave praise to Maryland for the work we accomplished in forming 30 Future Nurses Clubs. Our film, "The Girl with the Lamp," was mentioned in several state reports as having been purchased or borrowed for their Auxiliary use. Our "Future Nurses Convention" was cited as a most worthy effort for Nurse Recruitment.

#### *Tuesday, June 22, 1954*

After roll call by the Constitutional Secretary, Mrs. George H. Yeager, at which time we had 5 members present, we heard the President's address. After reporting the many accomplishments of the National Auxiliary, our President stated that Highway Safety has become her chief interest. She will turn her attention to that upon retirement from the A. M. A. Auxiliary Office. Noting that traffic killed more Americans last year than the Korean War did, Mrs. Schaefer said she "will work to save healthy life as well as diseased life."

The morning meeting then adjourned for lunch and a fashion show, at the Mark Hopkins Hotel. The guest speaker, Lynn T. White, Jr., Ph.D., President of Mills College, gave an interesting historical talk on "The Changing Past." Dr. White said, "History has long been written by the thin upper crust, the literate 5%, of the population while the long ignored 95% of illiterate peasantry produced the sub-history of the ages. There is no past. Only our present thinking of what has gone before us. The past is changing just as fast as the art of medicine is changing."

The afternoon session opened with the state reports; Eastern Region came first. Maryland was proud to make an outstanding one on Nurse Recruitment, the organization of Wicomico County Auxiliary and a permanent Doctor's Day, March 30, by Governor's Proclamation. Our A.M.E.F.

contribution enabled us to receive a special honor, a certificate of achievement. Mrs. Frank Gastineau, National Chairman, requested and set a goal of \$1.00 average contribution per member in each state. Maryland contributed \$2.25 a member and was presented with a certificate of merit. Only six certificates were presented.

#### *Wednesday, June 23, 1954*

An impressive "In Memorial" service was conducted by Mrs. C. R. Pearson. State reports of the North Central Region and reports of Chairmen of Special Committees followed.

*Civil Defense.* Medical care is the most vital of all phases of national defense. An effective program is the duty of the Auxiliary. See that your doctor husband knows his place in the county Civil Defense plan.

*Nurse Recruitment.* Mrs. Harold Johnson, National Chairman, praised the work of Maryland and felt that we had made an outstanding contribution to Nurse Recruitment.

At the luncheon in honor of Mrs. Leo J. Schaefer, President and Mrs. George Turner, President-Elect, the American Medical Education Foundation was presented with memorial funds totaling \$8,000 by the Auxiliary. Two \$100 presentations were made to the "World Medical Association" and the "Committee on Careers in Nursing" by the Auxiliary. State reports continued through the afternoon.

#### *Thursday, June 24, 1954*

The morning consisted of Election of Officers, followed by Installation of Officers, presentation of the President's Pin and Mrs. George Turner's Inaugural address.

On Thursday evening the Annual Dinner was held at the Fairmont Hotel. A clever skit, entitled "There Is a Doctor in the House!", written by Mrs. James Phalen, a member, and presented by the members of the San Francisco Auxiliary, was much enjoyed.

#### *Friday, June 25, 1954*

Mrs. George Turner, the newly elected National President, talked to Presidents and Presidents-Elect of the states. She repeated the words of the past presidents by saying, "Again this year we will light our candles from the torch of our predecessors."

Her keynote this year is "Health Service in Communities." She mentioned six points necessary to create a good leader: (1) Enthusiasm; (2) Knowledge (Enthusiasm being placed ahead of knowledge); (3) Confidence; (4) Hard work; (5) One who can make decisions; (6) One who is unafraid.

Dr. Howard, Secretary of the A. M. A., talked on the accomplishments of the House of Delegates of the A. M. A. Mrs. Leo J. Schaefer met with the House of Delegates, this being the first time an Auxiliary President has appeared. The National Osteopathic Association has asked for recognition by the A. M. A. The A. M. A. asked for permission to study the curriculum and campus of the six schools in the country before making a decision. The Osteopathic Association has not yet agreed to that. Until they do, the A. M. A. will make no amalgamations or decisions. Dr. Howard spoke of unethical medical procedures such as panel systems tied up with advertising. No decision on this question was made, as it was turned over to the Board.

Last year 257 bills were studied that had medical implications. Do not think the fight against socialized medicine has been won. A change of legislation has not solved the problem. We are urged to read our material from the A. M. A. and when our State Chairman on Legislation asks us to write our Congressmen, it is important that we do, as Congress speaks only one language, "Register and Vote." They are beginning to have respect for the A. M. A. They realize it is the voice of the Doctors. Congress did not accept the A. M. A. recommendations on Social Security of Doctors until letters came in by the hundreds from Doctors throughout the country.

Mr. Jones talked on A. M. E. F. and he stated \$805,000 was raised from January to June of 1954; \$56,000 from Auxiliaries. Seventy-nine medical schools in 56 cities supply the need of the nation. Many states use memorial cards as a means of raising funds for A. M. E. F. Mrs. Frank Gastineau, National Chairman, asked for a dollar a member from each state. Maryland averaged \$2.25 a member.

Mr. Edlow talked on the publication of "Today's Health" which is the only authentic health magazine published today. Mrs. Richard Stover, National Chairman, has new ideas and wishes to get the material into the hands of the State Chairmen.

Mrs. Henry from the National Committee on Careers in Nursing talked. She said we are getting nurses but need more. We have 330,000 graduate nurses, 76,000 practical nurses and 102,000 in nursing in the country. We need 50,000 professional nurses and 15,000 practical nurses each year. Last year we had 43,000 professional and 9,000 practical nurses graduate. They asked state chairmen to ally with Careers in Nursing.

An amendment was proposed by the A. M. A. and read before our body to be passed upon. It was introduced into the A. M. A. through the Academy of General Practice. It concerned doctors and their families. They sponsor a "Physician For Every Doctor" and asked the wives of physicians to urge their husbands to have yearly physical examinations. This amendment was originated by a physician in Washington State who felt if, he had checked on his own health, he might have learned that he had cancer of the lung before it was too late.

Like the cobbler's children who have no shoes, the doctor's family may get the poorest medical care and attention, says the American Academy of General Practice. To combat this situation, the Academy has launched a nationwide project best described by its slogan, "A Family Doctor for Every Doctor's Family." Ironically, the project's sponsor, Dr. Merrill Shaw, Seattle, Washington, vice president of the Academy, is dying of cancer. The project is the last of his many contributions to medicine.

The Academy has asked women's auxiliaries of state and county medical societies and the American Medical Association to help sponsor the project. Its goal is to see that doctors and their families receive better medical care.

Dr. Shaw is convinced that physicians and their families receive "hop-skotch" medical attention, neglect their own health, and seldom have a thorough check-up. Those who consult specialists tend to forget that each specialist knows only a small part of a patient's complete medical history. During his twenty years as a general practitioner, Dr. Shaw does not recall that a single doctor ever came to him for a physical examination.

Records show that the country is losing many highly-trained doctors at the peak of their careers. Much of this loss is due to preventable illness. As

pointed out in a recent monthly publication, more than half the doctors in private practice work sixty or more hours a week. Their failure to practice what

they preach gives them a death rate higher than other professional men. Heart ailments are the doctor's occupational disease.

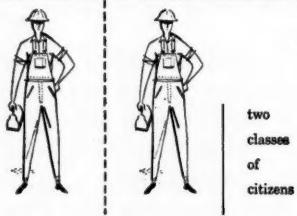
#### FEDERAL WORKERS HEALTH INSURANCE PLAN PRESENTED

A. M. A. Washington Letter, No. 81

The administration's plan for contributory health insurance for 2.3 million federal civilian employees was presented to Congress July 22. The Civil Service Commission, in submitting the plan to Post Office and Civil Service Committees of the Senate and House, said it was part of President Eisenhower's 9-point program for "a well-rounded federal career system." Each agency would be authorized to negotiate with commercial or non-profit hospitalization and medical care plans for their employees and dependents on a voluntary basis. The government would contribute up to \$26 annually for each worker who would pay the remainder on a payroll deduction basis. The commission estimates the annual cost to the government at \$60 million. The final plan was formulated under the direction of Nelson Rockefeller, Under-secretary of the Department of Health, Education, and Welfare. Commission officials said legislation was being presented now for study in preparation for action in the Congress convening in January.

#### In Viewing the VA Medical Program . . .

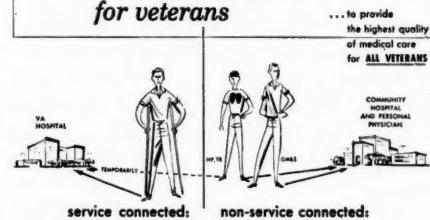
##### *effects of present veterans medical legislation*



It is the belief of the medical profession that it is unsound to authorize free lifetime medical care for veterans who suffered no mishap in uniform, while other citizens with no military background must pay their own way. Although the two men above are identical, they represent "two classes of citizens"—the veteran with no service-connected disability who is granted medical care at federal expense, and the non-veteran who must personally assume responsibility for his medical care.

#### In Viewing the VA Medical Program . . .

##### *the medical profession's policy on medical care for veterans*



The medical profession stands for the highest quality medical care for all citizens. Veterans, as citizens, should accept the responsibility for their own health needs—unless they became disabled as a result of military service; then it is the responsibility of the Veterans Administration to provide medical care and hospitalization. Because many communities do not as yet have adequate facilities to care for war veterans with non-service-connected tuberculosis or neuropsychiatric disorders, the medical profession recommends that the VA continue—on a temporary basis—to treat these patients.

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## Coming Meetings

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### WOMAN'S AUXILIARY TO THE BALTIMORE CITY MEDICAL SOCIETY

MRS. E. RODERICK SHIPLEY, *President*

MRS. JOHN B. DEHOFF, *Secretary*

MRS. WHITMER B. FIROR, *Treasurer*

*Wednesday, October 6, 1954, 11:00 a.m.*

Faculty Building, 1211 Cathedral Street, Baltimore

Poliomyelitis—The Present Status. Edward Davens, M.D., Chief of the Bureau of Preventive Medicine, Maryland State Department of Health.

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### CANCER SECTION

HOWARD D. FISHBURN, M.D., *Chairman*

ARTHUR G. SIWINSKI, M.D., *Secretary*

*Wednesday, October 13, 1954*

National Cancer Institute, Bethesda

Details of the programs will be sent to regular members. Anyone else interested may call the secretary at Ve 7-5797.

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### JOINT MEETING OF THE ORTHOPEDIC SECTION AND THE BALTIMORE SECTION OF THE RADIOLOGICAL SOCIETY

ALLEN F. VOSHELL, M.D., *Chairman*

WILLIAM P. HORTON, M.D., *Secretary*

JOHN DE CARLO, M.D., *Chairman*

PAUL N. ROMAN, M.D., *Secretary*

*Tuesday, October 19, 1954, Marine Hospital*

Cocktails 5:30 p.m. Dinner 6:00 p.m.

Scientific Meeting 8:00 p.m.

Discussion of Bone Tumors. H. L. Jaffe, M.D., Guest Speaker

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### THE COMMITTEE FOR THE STUDY OF PELVIC CANCER

Sponsored by the Maryland Division of the American Cancer Society and the Medical and Chirurgical Faculty.

RICHARD W. TELINDE, M.D., *Chairman*

BEVERLEY C. COMPTON, M.D., *Secretary*

1211 Cathedral Street, Baltimore

*Thursday, October 21, 1954*

*5:00 to 6:00 p.m.*

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### SECTION OF GENERAL PRACTICE

LOUIS R. MASER, M.D., *Chairman*

K. KENNETH KRULEVITZ, M.D., *Secretary*

1211 Cathedral Street, Baltimore

*Thursday, October 28, 1954, 9:30 p.m.*

The General Practitioner's Relation to the Patient. Louis Krause, M.D.

**AMERICAN COLLEGE OF CHEST PHYSICIANS**

October 31, 1954

The Potomac and Virginia Chapters of the American College of Chest Physicians will hold a joint meeting, opening at 9:30 a.m., Sunday, October 31, 1954, at the Shoreham Hotel, Washington, D. C.

All physicians are cordially invited to attend. There is no registration fee for guests or members.

The program will include symposia on Cardiac Surgery and Bronchogenic Carcinoma, a panel discussion on Problems Encountered in the Present Day Management of Tuberculosis and round table luncheons on Pulmonary Emphysema and Evaluation of Patients for Cardiac Surgery.

**OPHTHALMOLOGICAL SECTION**FRED M. REESE, M.D., *Chairman*HERMAN K. GOLDBERG, M.D., *Secretary*

Hopkins Club

Friday evening, November 19, 1954

Dinner 6:15 p.m. Meeting 8:00 p.m.

Dr. William F. Hughes, Jr. will speak on "Diagnosis of Intraocular Tumors."

**A.M.A. NEWS RELEASE—WASHINGTON OFFICE****THE MONTH IN WASHINGTON**

Washington, D. C.—While Congress didn't enact all the health bills President Eisenhower's administration wanted to put through, it did mark up an imposing record of accomplishment. In fact it passed more health and medical legislation than any Congress in many, many years. The AMA actively supported most of the bills finally enacted, and opposed none of them.

Four important new laws were written into the statutes before the session ended—expansion of the Hill-Burton hospital construction program, expansion of the vocational rehabilitation program, amendment of the income tax law to allow more liberal deductions for medical expenses, and transfer of the responsibility for health of the Indians to U. S. Public Health Service.

For years a group of state health officers have been working to bring about the transfer of Indian hospital and medical service from the Indian Bureau in the Department of the Interior to Public Health Service in what is now the Department of Health, Education, and Welfare. The health officers could show beyond any question that the Indians were receiving far less medical care than the rest of the population. They maintained that if the Public Health Service were made responsible for the Indians' health, there would be a rapid change for the better on the reservations.

What might be called governmental inertia succeeded in holding up the legislation for a time, but this Congress decided to make a shift. Public Health Service, which will take over on the reservations next July 1, already has plans under way to insure the Indians more and better medical care.

The demands for a more dynamic vocational rehabilitation program have been building up outside the federal government as well as in Washington. The problem facing this admin-

istration was to get more people rehabilitated but at the same time to induce the states to take a more active part in the work. The law now enacted promises to do this. It authorizes gradual increases in the federal appropriations, but at the same time is aimed at bringing the states up to the position of full financial partners by the end of five years. The goal is to rehabilitate at least 200,000 persons annually, in place of the present 60,000.

If local communities are willing to raise from one-third to one-half of the cost, the new Hill-Burton program should result in the construction, within three years, of possibly a half billion dollars in new facilities—rehabilitation centers, diagnostic-treatment clinics, chronic disease hospitals, and nursing homes. (This program was discussed in detail last month in this space.) The new construction will be in addition to the continuing Hill-Burton grants for complete hospitals.

On the medical cost deduction question, too, economists long have felt that families with unusually large medical expenses should be given more liberal tax deductions. The new law will allow them to deduct medical expenses in excess of three per cent of taxable income. Under the old law the figure was five per cent. A \$3,000-income family with \$150 in medical expenses under the old law could deduct nothing, but under the new law \$60. The Treasury estimates that the total saving to families will be \$30 million.

The general public probably read and heard more about the one bill that was defeated—reinsurance—than it did about all the health and medical legislation that passed. That defeat (in the House) was a surprise and a disappointment to the President. His advisors might have told him that all was not well, but obviously they did not. Opposition was not confined to the AMA. Also lined up against it were most of the health insurance companies, the U. S. Chamber of Commerce and a number of other professional groups. The labor unions would accept it, but wouldn't work to get it. Most significant of all, it had lukewarm support at best from the lawmakers who know most about it, the Senate and House committees that conducted the hearings.

#### PHS ALLOCATES 60% OF CURRENT YEAR'S RESEARCH FUNDS

The AMA Washington Letter, No. 83

Sixty per cent of the Public Health Service medical grant money appropriated to the National Institutes of Health for fiscal 1955 already has been allocated. Approximately one-third of the 1,442 research awards went to new projects and the remainder for continuing existing studies. The grants, totaling \$14,685,671, are for "basic and applied research in the major diseases afflicting Americans today."

Of the seven Institutes of Health, the National Cancer Institute distributed the largest number of new grants: 92, totaling \$981,074. Chemotherapy of leukemia and allied forms of cancer was listed as a typical subject of NCI research. The National Heart Institute has the largest number of continuation grants: 213, totaling \$2,283,370. Scientific investigations of NHI include effects of hormones on hardening of the arteries, edema mechanisms occurring in heart failure, synthesis of compounds acting on the heart, and effects of temperature and humidity on the circulatory system. A total of \$33,918,000 was appropriated for PHS medical research for the current fiscal year.

REQUEST FOR USED MEDICAL JOURNALS, ETC.

ST. GEORGE'S MISSION HOSPITAL

Punalur, P. O., Travancore, S. India

Dr. T. K. Thomas,  
Hon. Medical Superintendent.

Punalur,  
20th February '54

Ref:

To

Secretary, Medical and Chirurgical Faculty of Maryland,  
1211 Cathedral Street, Baltimore, Maryland,  
U.S.A.

Gentleman,

I wish to inform you that the above Hospital is a non-profit organization situated in a hilly village and working among the poor labour classes of the locality and its suburbs. As good medical literatures are very few in this part of the world, a small library is started recently attached to the above Hospital with the idea of collecting used medical journals, books, bulletins, reprints of articles and Transactions of Medical Societies from all available sources in foreign countries so that up-to-date knowledge in Medical Practice may be obtained.

Further Ayurvedic and Unani systems of Medicine are very troublesome competitors to Allopathic system here and proper equipments and medical literatures are highly essential for the successful management of the Hospital.

In the light of the above circumstances, I request you to kindly issue a News Note in your monthly Bulletin and also in your Society Medical Journal requesting the sympathetic members of your Society to send me their used medical journals with all available backward copies, Medical books, reprints of articles and other useful medical literatures and also second-hand Surgical Instruments, Medical Appliances, Laboratory equipments etc., so that many of our poor patients may directly and indirectly be benefitted by them.

This Act of Kindness and Charity by the members of your Society will ever be remembered which lapse of time cannot wipe away from our memory.

Thanking you very much for all your valuable services,

Yours Very Truly,  
T. K. Thomas  
Hon. Medical Superintendent.

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POLIO VACCINE TRIAL NEEDS PHYSICIANS' AID AS IT MOVES INTO  
EVALUATION PHASE

More than 600,000 children have completed three inoculations, in the field test of the trial polio vaccine developed by Dr. Jonas E. Salk of the University of Pittsburgh. The emphasis now shifts to the evaluation study under the direction of Dr. Thomas Francis, Jr., University of Michigan School of Public Health. The validity of the evaluation is dependent upon data gathered on poliomyelitis cases in the test groups, *including those children in the first three grades who did not get vaccine.*

In addition, data on cases among family members of participating children are an integral part of the study. Since the number of poliomyelitis cases among the test groups may not be large, it is essential that all cases are completely reported. Early diagnosis, prompt reporting and follow-up, and the securing of *necessary epidemiological information and laboratory specimens* are important factors in the evaluation.

An outline of procedures and copies of necessary forms have been sent to local and state health authorities. It is important that physicians in areas where vaccinations were not given, cooperate in the study by notifying local or state health officers of cases occurring among children who participated in the trials and then migrated to another area and children who go to summer camps. Local health officials also need information on participating children who receive injections of Gamma Globulin.

This phase of the study will depend, to a large degree, on the wholehearted cooperation of practicing physicians.